Provider Guidelines

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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. To enroll, practitioners may contact DHCS Provider Enrollment Division:

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

Telephone: (916) 323-1945

DHCS Provider Enrollment Division

DHCS Provider Enrollment Division assists providers as follows:

- Accepts and verifies all applications for enrollment
- Enrolls each provider using his or her 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

Participation Requirements

Introduction

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

1. Federal Laws and Regulations, W&I Code and CCR

Compliance with the Social Security Act (*United States Code*, Title 42, Chapter 7); the *Code of Federal Regulations*, Title 42; 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. Record Keeping

Agreement to keep necessary records. Refer to the *Provider Regulations* section of this manual for specifics.

3. Non-Discrimination

Non-discrimination against any recipient on the basis of race, color, national or ethnic origin, sex, age, or physical or mental disability.

Change of Pay-To and/or Mailing Address

Address Change Forms for Providers

A change of pay-to address, mailing address, telephone number or status must be submitted with the Provider Application and Validation for Enrollment (PAVE) portal on the DHCS website (*www.dhcs.ca.gov*).

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

See Inpatient, Outpatient and Long Term Care provider information below.

Inpatient, Outpatient and Long Term Care Providers

Inpatient, Outpatient and Long Term Care providers (institutional providers) must contact the Licensing and Certification (L&C) Division of the California Department of Public Health (CDPH) to change their business addresses or other information. To change a pay-to address, institutional providers must submit *a Medi-Cal Supplemental Changes* (DHCS 6209) form to the DHCS PED, at the address on the following page, to prevent unauthorized pay-to address changes. The DHCS 6209 form can be retrieved from the Forms page of the Medi-Cal website (*www.medi-cal.ca.gov*). Institutional providers include:

- Alternative Birthing Centers
- AIDS Waiver
- Chronic Dialysis Clinics
- Community-Based Adult Services (CBAS) centers (those billing fee-for-service only)
- Community Clinics
- Exempt from Licensure Clinics
- Federally Qualified Health Centers (FQHC)
- Heroin Detoxification
- Home Health Agencies (HHA)
- Hospices
- Hospitals

Inpatient, Outpatient and Long Term Care Providers ‹‹(continued)››

- L.A. Waiver
- Level A Nursing Facilities
- Level B Nursing Facilities
- Rehabilitation Clinics
- Rural Health Clinics (RHC)
- Subacute
- Surgical Clinics (non-physician owned)

Clinical Laboratory Providers

Clinical laboratory providers must contact Laboratory Field Services at (510) 620-3800 to report a change in business address or other information. Clinical laboratory providers reporting a change in their Medi-Cal pay-to address or mailing address must use the PAVE portal on the DHCS website (*www.dhcs.ca.gov*).

Pharmacy Providers

Pharmacy providers reporting changes should consider whether the change requires the Board of Pharmacy to issue a new Retail Pharmacy Permit. The Board of Pharmacy can be contacted at (916) 445-5014. If the change requires the Board of Pharmacy to issue a new Retail Pharmacy Permit, the Pharmacy provider is required to complete a new application with the PAVE portal on the DHCS website (*www.dhcs.ca.gov*). If a new Pharmacy Retail Permit is not required as a result of the change being reported, the Pharmacy provider is required to submit a supplemental application with the PAVE portal on the DHCS website (*www.dhcs.ca.gov*).

Where to Submit Address/Status Changes

Pay-to address changes submitted by institutional providers on the 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

Enrollment Information

Overview

In response to fraud and abuse in the Medi-Cal program, DHCS has adopted regulations governing provider enrollment. These regulations require the submission of consistent information that can be used to verify the identity and qualifications of individuals and groups requesting Medi-Cal provider status, and establish requirements for the enrollment of most non-institutional providers who submit fee-for-service claims. Institutional and other providers licensed or certified by the L&C Division and providers otherwise approved for participation in the Medi-Cal program by other State agencies, such as the Department of Aging or the Department of Alcohol and Drug Programs, are not impacted by these regulations.

Medi-Cal Supplemental Changes

DHCS must have current provider information. This is the responsibility of the provider who 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. DHCS has developed the supplemental change application that must be submitted using the PAVE portal on the DHCS website (*www.dhcs.ca.gov*) to report the following changes, additions or actions:

‹‹**Medi-Cal Supplemental Changes (continued)**››

- Pay-to address, mailing address or phone number changes
- Medicare/other NPI
- Change in business activities (for Durable Medical Equipment providers and providers of incontinence medical supplies)
- Medical transportation driver/pilot or vehicle/aircraft information, hours of operation or geographic areas served
- Doing-Business-As (DBA) or Fictitious Business Name
- Clinical Laboratory Improvement Amendment (CLIA) certificate number and effective date
- Deactivation of provider number(s) or group provider number(s)
- New pharmacist-in-charge for Pharmacy providers
- Changes of less than 50 percent of the ownership or control interest in the provider or provider group
- New Seller's Permit, license or certificate

Institutional Providers

Changes to the provider's business address or other information must be reported to the local L&C Division of CDPH. Institutional providers may submit the DHCS 6209 form to DHCS PED to report a change of pay-to address only.

‹‹Provider Identification Numbers (PINs)

Providers receive their initial Provider Identification Number (PIN) as part of their program enrollment.

Methods for PIN Confirmation or Replacement

There are two methods for requesting confirmation or replacement of a current PIN. Many Medi-Cal fee-for-service providers with seven-character Provider Identification Numbers (PINs) may request a Telephone Service Center (TSC) agent at 1-800-541-5555 to confirm or reset their PIN. Other providers complete and mail a *Medi-Cal Supplemental Changes* (DHCS 6209) form to the Department of Health Care Services (DHCS) Provider Enrollment Division. Refer to “How to Obtain Enrollment and Supplemental Changes Forms” on a following page of this section for information.

Once the preceding items are verified, the TSC agent can confirm or reset the PIN and release the PIN over the telephone. Providers do not need to wait for notification through the mail. If the information cannot be validated, the PIN cannot be reset.

If the information is not adequate, the provider may have another qualified person in their office reattempt the PIN confirmation/reset or they may request PIN confirmation/reset using the existing paper process. Refer to “How to Obtain Enrollment and Medi-Cal Supplemental Changes Forms” elsewhere in this section.

PIN confirmation and reset letters are returned to providers’ “Pay-to” address on file.

Due to certain provider requirements, PIN confirmations and resets through TSC are not allowable for select providers, including, but not limited to, dental and mental health providers. PIN resets may take several hours to activate based on system refresh cycles.››

‹‹Temporary PINs

A temporary PIN can be issued by the Point of Service (POS)/Internet Help Desk to providers who do not have a permanent PIN or have misplaced their permanent PIN. A temporary PIN is valid until midnight of the day it was issued.

Providers can use a temporary PIN to verify eligibility and perform Share of Cost transactions. A temporary PIN can only be used on Supplemental Automated Eligibility Verification System (SAEVS). A temporary PIN cannot be used with the Automated Eligibility Verification System (AEVS), Provider Telecommunications Network (PTN) or on the Medi-Cal website.

To obtain a temporary PIN, providers call the POS/Internet Help Desk at 1-800-427-1295. SAEVS can be accessed by calling 1-800-427-1295. Choose option 4 and then option 2.

Mental Health Provider PINs

Mental health providers must send a letter requesting a permanent PIN on company letterhead to the following address:

County Customer Services Section
MS 2704
1500 Capitol Avenue
P.O. Box 997413
Sacramento, CA 95814

Provider Telecommunications PIN Information

For PIN information related to use of the Provider Telecommunications Network, providers can refer to “Provider Identification Number (PIN)” in the Part 1, *Provider Telecommunications Network (PTN),* provider manual section.››

Enrollment Applications

See below for information about enrollment applications.

Change of Ownership or Control Interest of 50 Percent or More

Providers must submit a new enrollment application with PED via the PAVE portal if the provider undergoes a change of 50 percent or more in ownership or control interest.

Reporting Additional Business Locations

Providers or provider groups that want to submit claims for services rendered at an additional business address are required to submit an enrollment application with PED via the PAVE portal, as applicable to the provider type. A new application must be submitted via the PAVE portal for each additional location.

Application Deficiencies

Applicants are allowed 60 days to resubmit their corrected application when DHCS returns it deficient.

If an applicant fails to resubmit the application to DHCS within 60 days, or fails to remediate the deficiencies identified by DHCS, the application shall be denied. Applicants denied for failure to resubmit in a timely manner or for failure to remediate may reapply at any time.

Adding Rendering Providers to a Provider Group

Rendering providers in good standing may join existing provider groups. The group may begin billing for the services delivered by an already enrolled rendering provider by affiliating with the rendering provider via the PAVE portal. Rendering providers need to apply to Medi-Cal only once but must affiliate with each subsequent group they work for via the PAVE portal. To initially enroll as a rendering provider, the applicant needs to submit a complete application package to PED with the PAVE portal on the DHCS website (*www.dhcs.ca.gov*).

How to Apply for Enrollment or Submit Supplemental Changes Via the PAVE Portal

To submit enrollment and supplemental applications, providers can access the PAVE portal on the DHCS website (*www.dhcs.ca.gov*).

How to Obtain Enrollment and Supplemental Changes Forms

‹‹Enrollment forms and the *Medi-Cal Supplemental Changes* (DHCS 6209) form are available for certain provider types by contacting the Telephone Service Center (TSC) at 1-800-541-5555 (select option 2). Completion instructions are included with the forms. These forms also are available on the Medi-Cal website at *www.medi-cal.ca.gov*, by clicking the “Forms” link.›› Questions may be directed to DHCS by calling (916) 323-1945, Monday through Friday, 8 a.m. to 5 p.m.

Obligations To Recipients

Eligibility Verification Obligates Provider to Render Services

When a provider elects to verify a recipient's Medi-Cal eligibility, the provider has agreed to accept an individual as a Medi-Cal patient once the information obtained verifies that the individual is eligible to receive Medi-Cal benefits. The provider is then bound by the rules and regulations governing the Medi-Cal program once a Medi-Cal patient has been accepted into the provider's care.

After receiving verification that a recipient is Medi-Cal eligible, a provider cannot deny services because:

- The recipient has other health insurance coverage in addition to Medi-Cal. Providers must not bill the recipient for private insurance cost-sharing amounts such as deductibles, coinsurance or copayments because such payments are covered by Medi-Cal up to the Medi-Cal maximum allowances. Providers are reminded that Medi-Cal is the payer of last resort. Medicare and Other Health Coverage must be billed prior to submitting claims to Medi-Cal.
- The recipient has both Medicare and Medi-Cal. Providers must not treat the recipient as if the recipient is eligible only for Medicare and then collect Medicare deductibles and coinsurance from the recipient, according to a 1983 United States District Court decision, Samuel v. California Department of Health Services.
- The service requires the provider to obtain authorization.

Circumstances That Exempt Providers From Rendering Services

A provider may decline to treat a recipient, even after eligibility verification has been requested, under the following circumstances:

- The recipient has refused to pay or obligate to pay the required Share of Cost (SOC).
- The recipient has only limited Medi-Cal benefits and the requested services are not covered by Medi-Cal.
- The recipient is required to receive the requested services from a designated health plan. This includes cases in which the recipient is enrolled in a Medi-Cal managed care plan or has private insurance through a Health Maintenance Organization or exclusive provider network, and the provider is not a member provider of that health plan.
- The provider cannot render the particular service(s) that the recipient requires.
- The recipient is not eligible for Medi-Cal for the month in which the service is requested.
- The recipient is unable to present corroborating identification with the Benefits Identification Card (BIC) to verify that he or she is the individual to whom the BIC was issued.

Payments From Recipients

When Medi-Cal eligibility has been verified, providers must submit a claim for reimbursement according to the rules and regulations of the Medi-Cal program. Providers must not attempt to obtain payment from recipients for the cost of Medi-Cal covered health care services. Payment received by providers from DHCS in accordance with Medi-Cal fee structures constitutes payment in full.

Provider Billing after Beneficiary Reimbursement

For information about billing Medi-Cal after reimbursing the beneficiary, refer to the *Provider Billing after Beneficiary Reimbursement (Conlan v. Shewry)* section of the Part 2 manual.

Non-SOC Payments Must be Refunded

Unless it is used to satisfy an SOC requirement, any payment received from a Medi-Cal recipient must be refunded upon receipt of a Medi-Cal *Remittance Advice Details* (RAD) reflecting payment for that service.

Rendering Provider

Rendering Provider Billing by Group or Clinic

When services are rendered by an individual professional, but the billing is done by a group or clinic, each rendering provider member of a group or clinic must have their own National Provider Identifier (NPI) number registered separately from the group's NPI. Refer to the claim completion section of the appropriate Part 2 manual for instructions.

Enrolling Hard Copy Billing Intermediaries

Introduction

Section 14040.5 of the *Welfare and Institutions Code* (W&I Code) requires DHCS to enroll billing intermediaries. This law was implemented to help identify billing intermediaries who fraudulently bill the Medi-Cal program for providers and who willfully misrepresent themselves. This legislation provides guidelines for DHCS to enroll hard copy Medi-Cal billing intermediaries. Failure to comply with this legislation could result in suspension from billing the Medi-Cal program.

DHCS requires hard copy Medi-Cal billing intermediaries to:

- Register with DHCS
- Obtain an identifier code
- Enter the identifier code in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim submitted for payment

DHCS requires all Medi-Cal providers to:

- Inform DHCS when using hard copy-only intermediaries

Billing intermediaries include any entity including a partnership, corporation, sole proprietorship or person billing Medi-Cal on behalf of a provider pursuant to a contractual relationship with a provider. People directly employed by the provider who prepare and submit claims for the provider are not subject to this legislation.

Instructions to Providers Who Use Hard Copy Billing Intermediaries

All providers who use hard copy billing intermediaries must notify DHCS by completing the *Provider: Medi-Cal Hardcopy Biller Notification Form*. Providers are to return this form to DHCS Provider Enrollment Division at the address noted on a previous page. ‹‹Because the billing companies may not receive notification of these requirements, providers should also notify the billing companies by sending them the *Biller: Medi-Cal Hardcopy Biller Application Agreement*, along with a copy of this manual page.››

Billing Intermediary Registration Numbers

All billing intermediaries are responsible for submitting *the Biller: Medi-Cal Hardcopy Biller Application Agreement* to DHCS Provider Enrollment Division. Once DHCS receives the application form, the billing services will be notified of their registration number. The billing services will then be required to enter this number in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) on all claims they submit to Medi-Cal.

Where to Submit Notification and Application Forms

Both the provider notification and the biller application forms (or any future changes) should be submitted to DHCS Provider Enrollment Division using the address and telephone number listed on a previous page.

Instructions for CMC Submitters Who Also Bill Hard Copy

Billing companies that submit Computer Media Claims (CMC) in addition to hard copy claims do not need to apply. Instead, they should enter their CMC submitter number in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) when billing hard copy claims.

Electronic Claim Submission

Introduction

Providers may submit claims to the California MMIS Fiscal Intermediary via telecommunications and other electronic media in the manner and format approved by State *Welfare and Institutions* Code (W&I Code), Section 14040. Regulations for participation are in *California Code of Regulations* (CCR), Title 22, Section 51502.1.

Participation as an electronic claims submitter is open to most Medi-Cal providers, including Child Health and Disability Prevention (CHDP) providers, assuming submitted claims are in an acceptable format. A submitter may be a billing service, or a provider may apply to become a submitter and also may act as a billing service for other providers.

To obtain approval from DHCS to submit claims electronically, providers and billing services must complete a *Medi-Cal Telecommunications Provider and Biller Application/Agreement* form (DHCS 6153) for electronic billing.

Applications/Agreement Forms

‹‹For information about application/agreement forms, refer to the *CMC* and *CMC Enrollment Procedures* sections in this manual.››

DHCS and Provider Tax Reporting Responsibilities

Introduction

DHCS is required by Federal Regulation, Section 3406 of the *Internal Revenue Service Code*, to report, on *Form 1099-MISC*, the amount of payments made to providers and the provider name/Taxpayer Identification Number (TIN) combination associated with these payments. DHCS will only issue a *Form 1099-MISC* on total annual RAD reimbursements greater than or equal to $600 per NPI.

Form W-9

DHCS sends a letter of notification and a copy of *Form W-9* to providers reported by the IRS as having an invalid name/TIN combination. An invalid name/TIN combination occurs when a provider enrolls in Medi-Cal with a TIN that the IRS shows as belonging to another person; for example, “Fred Jones” enrolls in Medi-Cal with a TIN that the IRS shows as belonging to “Bob Smith.”

If providers do not furnish DHCS with a completed *Form W-9* by the date indicated on the notice, DHCS is required to withhold 31 percent of the provider’s payments until a W-9 is received. These withheld amounts are forwarded to the IRS, and the provider must work with the IRS to receive any refunds through justification requests. To expedite the correction, providers should include a copy of the IRS payment coupon, or other document from the IRS, that displays both the provider name and TIN.

To prevent any withholding action, providers must return a completed and signed *Form W-9* to the appropriate address on the notice. The notification letter must accompany the W-9 to ensure credit to the correct provider number. Substitute forms will not be accepted.

Common TIN Errors

The following paragraphs outline some of the most common mistakes that cause invalid TIN information.

Name Changes

Providers change their business name and fail to notify DHCS. Because DHCS is still using the old name, the new name will cause a mismatch with IRS records. Providers must notify DHCS if their business name changes. Business name changes many times indicate an ownership change. Providers must be prepared to demonstrate that there has been no ownership change. If there has been a change, however, a new provider number will be issued with an application.

Social Security Numbers (SSN)

A provider is a partnership, corporation, hospital or clinic but is using an individual provider's Social Security Number (SSN). In this situation, providers should use the Employee Identification Number (EIN) of the partnership, corporation, hospital or clinic. Only use an SSN with an individual's name. Or, the provider is an individual provider who should be using his or her own SSN, but instead the provider is using the EIN of the partnership, corporation, hospital or clinic of which he or she is a member. Providers should always use their SSN in combination with their name.

EIN Mix-ups

EIN mix-ups occur when the provider is an operating unit of a larger business entity and the operating unit is using its own name with the larger business entity's EIN. This will cause a mismatch with IRS records. In this case, operating units should apply for their own EIN or use the name of the larger business entity. Mix-ups also occur when the provider is identifying the business with initials instead of his or her complete name, as recorded with the IRS. This will cause a mismatch of the provider's name and EIN with IRS records. Providers should use their complete name as recorded with the IRS. Or, the provider is a medical group practicing at a hospital and using the EIN of the hospital. Medical groups should use their own EIN.

Doing Business As (DBA)

The provider is a sole owner using his or her Doing-Business-As (DBA) name with his or her SSN or EIN of sole ownership. A sole owner must always put his or her name first; the DBA name may be listed second. In the past, with IRS approval, DHCS was able to accommodate physicians who used the TIN of the hospital in which they practiced, by adding the hospital's name to the DBA of their individual file. With the current IRS requirement, this is no longer valid and will cause a mismatch with their records.

Change of Ownership

The provider's business has changed ownership and the provider failed to notify DHCS. Since DHCS is still using the TIN and name of the previous owner, this will cause a mismatch with IRS records. Providers must notify DHCS when their business has changed ownership.

IRS Contacts

The second page of the W-9 forms gives more specific instructions about the name and TIN that should be submitted to DHCS in accordance with IRS reporting requirements. For more information about TINs, call the IRS at 1-800-829-1040. If you need information about how to apply for a TIN, call the IRS at (209) 452-4010, Monday through Friday, 6 a.m. to 6 p.m. For more information about SSNs, contact your nearest Social Security Administration district office.

Inactivated Providers

Introduction

DHCS conducts a periodic inactivation of providers who no longer bill the Medi-Cal program. Providers who receive Medi-Cal bulletins with their provider number on the mailing label, but who have discontinued billing Medi-Cal and have not received a payment during the last 12 months, may have their provider number inactivated.

Exceptions

Providers who are located where Medi-Cal is administered by a pre-paid health program directed by the county are exempt from periodic inactivation.

Physicians who render Medi-Cal services but have their billing done by a medical group under a group number will remain in “rendering provider” status and are not subject to periodic inactivation.

Inactivation for Returned Mail

DHCS regularly inactivates providers when their mail (including Medi-Cal checks) is returned by the post office as undeliverable. Therefore, providers who have changed their service and/or pay-to address, or any other related information, should notify DHCS Provider Master File Unit. (Refer to “Address Change Forms for Providers” in this section for additional information.)

Inactivation Benefits

Periodic inactivation reduces:

- Payment errors such as sending a payment to the wrong provider because the provider number entry is incorrect. (Billing tip: Check digits are not required but may be entered on claims to help prevent these errors.)
- The cost of handling return mail from providers who are no longer in business at the address indicated on the Provider Master File.

Reactivation Procedures

If a provider number has been inactivated but the provider wants to again participate in the Medi-Cal program, information on the Provider Master File must be updated. Providers wishing to reactivate their provider number must complete a provider-specific Medi-Cal enrollment application indicating their provider number and send it to DHCS Provider Master File Unit.

Terminating Participation

Voluntary Provider Termination

Providers may terminate their participation in the Medi-Cal program at any time. Written notification from the provider of voluntary termination is required to be made to DHCS Provider Master File Unit. Or the provider may choose to submit the *Medi-Cal Supplemental Changes* form (DHCS 6209) and request deactivation.

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.