Testing and Activation Procedures

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This section describes the testing and activation procedures required by Computer Media Claims (CMC) to ensure accurate file format, completeness and validity.

System Testing

Once enrollment is complete and a submitter number has been assigned, submitters must send a test file to the Medi-Cal test site (*sysdev.medi-cal.ca.gov*) to ensure accurate file format, completeness and validity. Any format problems discovered during the testing period must be corrected and a new test submitted for review prior to final approval. The CMC staff works directly with the submitter during all phases of the testing process.

Test submissions should contain a cross section of claim type data that can be expected in a production environment. The test file must consist of a minimum of 10 claims for each claim type to be billed. A maximum of 100 claims is allowed for testing. The test procedure must be completed for each applicable claim type.

A new test must be submitted when software is upgraded or the submission method changes.

Note: Claims contained on the test file will not be processed for payment. To test, submitters should use data from previously adjudicated claims. Submitters cannot send claims for adjudication until receiving written notification from the Department of Health Care Services (DHCS) stating they are in “active” status and are authorized for CMC billing.

Password

A submitter's password is required to transmit electronic claims. ‹‹Submitters are required to create an eight-character password and provide this password to the CMC Help Desk.›› Electronic submission tests cannot be processed without a submitter's password. The password will be activated within 48 hours of notification from the submitter.

Remarks Records

Submitters can include statements to support claim justification. Areas defined for statements are the Medi-Cal CMC *Remarks Records*, ANSI ASC X12N 837 v.5010 *Note (NTE) Segments*. These fields are optional.

Submitters using the Medi-Cal CMC format are required to test and be approved for *Remarks Records*. Claims with *Remarks Records* billed by submitters unauthorized for *Remarks Record* submission will be denied.

Testing for Multiple Media

Submitters may test for multiple media using the same submitter number. Once approval is received for each medium, submitters may use the same submitter number for all media.

Testing for Multiple Formats

Submitters may test for multiple formats using the same submitter number. Once approval is received for each format, submitters may use the same submitter number for all formats.

Telecommunications Testing

‹‹After receiving a CMC submitter number, the submitter should contact the CMC Help Desk to select a password. For more information, refer to the internet submission section in this manual.››

Evaluation Criteria

CMC evaluates the test file and determines if the following requirements have been met:

- ‹‹All format types
  - The claim data can be read by the claims processing system.››
  - Records and mandatory fields required for CMC are present and contain valid information (for example, provider number[s], submitter number, control records, claim records).

Test Results

Approximately two weeks after the test has been received, submitters receive a CMC test approval or denial letter with the test results of the submitted claims. CMC test letters and error reports are also available through the Medi-Cal test site (*sysdev.medi-cal.ca.gov*). Submitters must use their submitter ID with the prefix “CMCSub” and password (for example: “CMCSub001”).

Field Data Review

The test results also include a review of the field data formatting specifications. This review is not a requirement for CMC submission approval but is meant to assist in preventing claim denial due to format specification errors.

Error Message

Test claims with formatting errors are identified with the following statement: “The following examples of errors were encountered. If these errors are not corrected, your claims may be returned or denied.” The specific data field and error description will follow this statement. For example:

“05Info5” Recipient ID Must Be 9, 10, 14 Or 15 Characters Field Contains <12345678> Count 3 Claim Sequence=0002

This error message identifies the error code (05Info5), data field (Recipient ID) and correct format specification (9, 10, 14 or 15 Characters). It also identifies the actual field contents (12345678) and the sequential location (2) of the first claim found to contain the error, as well as the total count (3) of the error detected in the submission.

Note: Each specific error code, such as “05Info5” above, will be listed only once, regardless of the number of claims found to have this error.

Although the test submission may pass the critical test conditions, it is the provider’s responsibility to correct any errors prior to submitting claims for processing.

Retesting

In instances where data does not meet minimum standards of acceptability, the test results report (denial letter) will inform the submitter of the data elements in error. The submitter must make the necessary correction(s) and submit a new file for retesting. Additional testing is required until the claims file passes all applicable edits.

Billing Services: New Providers

Billing services that have already tested and received approval for CMC submission are not required to retest for each new provider, as long as they continue to use the same CMC submitter number, format, medium and claim type.

Note: A new application/agreement form is still required for all new providers.

‹‹Internet Submissions››

‹‹Test claims may be submitted on the Medi-Cal test site (*sysdev.medi-cal.ca.gov*).››

Activation

FI must approve each CMC provider/biller for electronic claim submission. Upon completion of the testing process, FI will notify DHCS. DHCS will then place the submitter in an “active” (production) status and will send the provider and/or billing service a letter authorizing CMC submission. The letter will include the name(s) of the providers/billers authorized to submit claims.

Note: Submitters may also view their activation status for HIPAA-related compliant claims transactions through the Medi-Cal test site (*sysdev.medi-cal.ca.gov*).

‹‹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.