CRISS
CHILDREN'S REGIONAL INTEGRATED SERVICE SYSTEM

CCS Claims Training Toolkit

A Desk Guide for CCS Staff

April 2023

Note: throughout this manual, information related to issuing authorizations and resolving claims is specific to CCS eligible children who are active in a:

- Classic CCS county, or
- WCM county but ***not*** enrolled in the Medi-Cal Managed Care Plan

This toolkit is not meant to be the authority over your own county's practices and does not take the place of DHCS guidance. The intent of this toolkit is to provide a starting point to help CCS staff find answers in the many resources that already exist in on-line manuals. For procedures in which an on-line resource does not exists, this guide provides a collection of tips and tricks that individual CCS County staff have discovered and found helpful over time. Use at your own discretion and feel free to add to it. Your own discoveries can be emailed to Laurie Soman, CRISS Project Director, at Lsoman6708@aol.com in order to be included in periodic updates of this toolkit.

Amendments

Version	Description	Date
1.0	Developed by a subcommittee of CRISS Claims Workgroup members: Elly Fitzgerald, Meredith Wolfe, Kaiala Anaya, Katy Carlsen, Kevin Clough, Nick Draper, Wendy Longwell, Chuck Montoya, Becky Penosa, Krista Peterson, Elaine Rodgers, Isela Smith, Laurie Soman, Debb Webb	9/5/2017
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Claims Training Toolkit

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Press Ctrl+F to search the manual by keyword.

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Part I—Background Information

The General CCS Claims Process

Part I – Background Information

CCS and Other Coverage

Health Care Delivery Model	Relevance to Understanding Claims
Fee-for-Service (FFS)	Fee-for-Service refers to services that are a benefit of Medi-Cal, but are not covered by a Managed Care Plan. Payments are made by the State Fiscal Intermediary on a fee-for-service basis.
Classic CCS	Classic CCS is a fee-for-service model. It is Carved-Out of the Managed Care Plan. For services related to the CCS eligible condition: • Provider must submit claims to the Medi-Cal Fiscal Intermediary with a SAR. ➢ Important – many providers do not know this and try to bill the Managed Care Plan • Managed Care Plan in a "Classic-CCS county" will deny a claim if it is CCS eligible. • Managed Care Plan pays claims for all other services *not* related to the child's CCS eligible condition. Phone Tip for Classic-CCS counties: When a provider calls to say a claim was denied, first ask "Did you submit the claim to [insert the name of your Medi-Cal Managed Care] or to the Fiscal Intermediary?
Whole Child Model (WCM)	SB 586 is legislation that was passed in September of 2016 which carves CCS services into managed care in 21 COHS counties no earlier than July of 2018, and extends the carve-out till 2022 for the remaining counties, or until the completion of an external evaluation. Full text of SB 586. In a WCM county: The Medi-Cal Managed Care Plan authorizes services for children enrolled in the health plan. Provider submits all claims to the Managed Care Plan, even for CCS services. Click the links on the left column to see a list or a map of WCM counties. For CCS eligible children who are not enrolled in the Medi-Cal Managed Care Plan, authorizations and claims are done as in a Classic CCS county.

Medi-Cal Managed Care—6 models in CA*: Map of Medi-Cal Managed Care Models in CA *Conditionally approved MCMC Models beginning 2024: 1. Regional Model 2. COHS and Single Model 3. Two Plan Model 4. GMC Model	1. **COHS**—County Organized Health Systems—beneficiaries receive services from a single, nonprofit health plan with county oversight. This is the only model that has Whole Child Model for CCS. 2. **GMC** – Geographic Managed Care—Beneficiaries may select from three or more commercial health plans 3. **Two-Plan Model—**Beneficiaries may select between one commercial health plan and one local initiative, which is a health plan with county oversight. 4. **Regional Model--**Beneficiaries may select one of two commercial health plans 5. **Imperial—**Beneficiaries may select one of two commercial health plans; one of the health plans has county oversight. 6. **San Benito**—Beneficiaries select either to receive managed care delivered by a commercial health plan or to receive fee-for-service through Medi-Cal.
PPO or OHC	**If a child has a PPO, the PPO is the primary coverage. CCS is the payer of last resort.** Provider still gets a SAR for CCS eligible services but must bill PPO first. This Other Health Coverage (OHC) is listed on the SAR.
HMO	**May not be eligible to CCS except for MTU-only, NBHS Diagnostic Case, HRIF, and other Newborn Screening Diagnostic Testing cases.** **HMO is primary payer.** HMO can deny for 'not a covered benefit'. If Explanation of Benefits (EOB) is received and client is Financially Eligible, CCS may review for medical eligibility. CCS cannot issue a SAR without a denial from HMO stating that they will not cover the requested service, (unless it is for one of the above exceptions).
Medicare Part D HCPI-NUM 320 (on MEDS QM screen)	Medicare is the primary payer for drugs **CCS will not pay for drugs when client has Medicare** CCS is primary for services
Medicare Part A & B HCPI-NUM 990 (on MEDS QM screen)	Medicare is the Primary Payer and must be billed prior to billing Medi-Cal

Co-pays and Deductibles	
Primary Insurance Payment	If the amount paid by the primary insurer **is greater than** the amount that Medi-Cal/CCS would have paid, the provider is considered to have been paid in full. No additional monies can be recouped from the State. If the amount paid by the primary insurer **is less than** the amount that Medi-Cal/CCS would have paid, the provider may bill Medi-Cal/CCS for the balance up to the Medi-Cal rate only. Make sure the providers are in-network. Do not issue a SAR to a provider that is out-of-network for the private insurance. If insurance denies a claim due to it being out- of-network, the CCS SAR will not pay. If a SAR is issued it will prevent the provider from billing the patient.
Deductible	Client/family is **not** responsible for deductible if client has Medi-Cal. • Insurance applies claim amount to deductible. • M/C will not pay above M/C rate. • If deductible is equal to or lower than the M/C rate, the provider will have to write off the balance.
Co-Pay	Providers can legally charge $1.00 co-pay for Medi-Cal clients. Medi-Cal will pay deductible 'up to' the M/C limit. If primary pays at or above the M/C limit the co-pay will deny. **Provider has agreed to accept a lower reimbursement when accepting M/C**
SOC	CCS can obligate (agree to pay) SOC in high dollar In-patient or Pharmacy cases. This makes sense financially if the cost of the service will be significantly greater than the SOC amount. A client with SOC is a straight-CCS (9K) case until the SOC is spent down each month. Once the SOC is met the services can be billed as full-scope M/C. State CCS Funds, or County Funds utilized for matching purposes, cannot be used to pay SOC obligations. Many counties have developed local written procedures for how to decide when to obligate a share of cost. Ask in your Regional Administrator group if you would like to see how other counties are doing this.

DDS Waiver	The DDS Waiver is for over-income families with a medically disabled child. The Waiver is issued by the local Regional Center. It allows Medi-Cal billing even when the family has OHC. If the family does not disclose OHC, State 3rd Party Liability will reverse Medi-Cal payments when OHC is discovered. The Provider must work directly with 3rd Party to get OHC information. OHC is not in MEDS and CCS does not have access to information. CCS SAR is not binding when OHC is discovered and Provider can now bill OHC. Determination by State is binding. Biller must bill OHC or, if State reverses because no OHC actually exists, biller may bill Medi-Cal again with proper documentation from the State, including proof of timeliness.

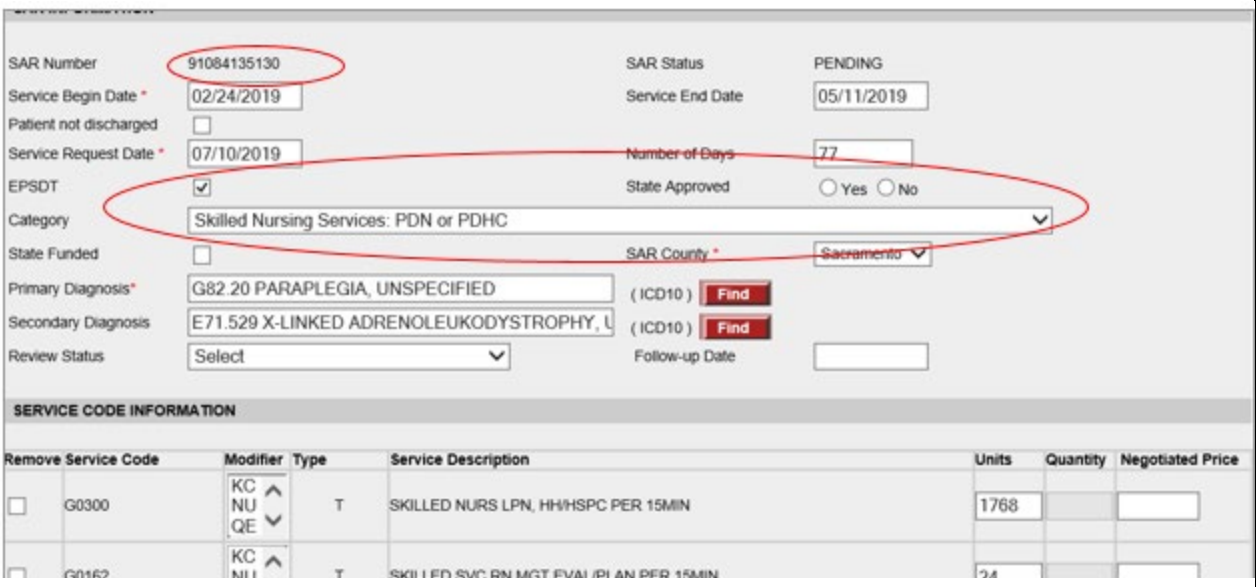
Claims submission timelines and payment amounts	1 to 6 months pays 100% 7 – 9 months pays 75% 10 – 12 months pays 50% Over 1 year payment is 0% Biller must have EOBs showing timely billing attempts. Only M/C EOB is acceptable. Rejections for billing OHC is not accepted. Biller must show billing rejections, appeals or CIFs to MC If billing is over 1 year old, claims must be resubmitted to Over 1 Year Unit

Pharmacy Benefits Medi-Cal RX and Magellan	
Magellan/Medi-Cal Rx	As of 1/1/2022, Medi-Cal transitioned all pharmacy services from Managed Care to Fee For Service. This new pharmacy benefit model is called Medi-Cal Rx. It is a single delivery system managed by Magellan Medicaid Administration, Inc.
What medications move to Magellan and what will stay with CCS	Medi-Cal Rx applies to all services deemed as 'pharmacy' and includes Out-Patient drugs (prescription and over the counter), enteral nutrition products and some medical supplies. Includes all services traditionally billed on a Pharmacy Claim Form. Claims that would pay using a CMS 1500 are still within the scope of CCS responsibility. If the item is claimed by NDC = Medi-Cal Rx, provider submits claim to Magellan If the item is claimed by a HCPC = issue a SAR, and provider will submit claim to the Medi-Cal FI just as before Medi-Cal Rx.
Medical RX Bulletins and News	This is a good place to search for news on specific pharmacy issues. You can also sign up for the subscription service so that you get an email anytime there is an update to a process in Medi-Cal Rx.
CCS and Medi-Cal Rx FAQs prior to implementation	 Medi-Cal Rx FAQs.pdf
Contract Drug List	The Contract Drug List (CDL) is a list of drugs that are on the Medi-Cal formulary. Drugs that are not listed may be covered subject to prior authorization. Medi-Cal Rx | Contract Drugs List (CDL)
First CI, SABA and designated users	First CI is read only access to the Medi-Cal Rx portal. This will allow you to view the status of claims and prior authorizations. SABA is a learning management system that contains tutorials on how to use first CI. Send an email to medicalrxprovisioning@magellanhealth.com to inquire about signing up for First CI access.

Magellan Customer Service	Customer Service Center (CSC) 800-977-2273 is available 24 hours a day, 7 days a week, 365 days per year Special Populations Clinical Liaisons (SPCLs) are available to support the CSC, Monday-Friday 8am-8pm, excluding holidays. CCS Staff can press option 5 to connect to the clinical liaison. Note: you will not hear an option for "5." It is a silent prompt. Magellan asks this prompt not be given to families. If you are calling for the first time, you will need to get an IVN (Individual Verification Number). Send an email to **MediCalRxEducationOutreach@magellanhealth.com** to request an IVN.

EPSDT	
Early and Periodic Screening, Diagnostic, and Treatment Supplemental Services. Federally mandated program that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.	
EPSDT SARs	Certain requests that are not a benefit of Medi-Cal can be authorized and paid by CCS using an EPSDT SAR. Check the EPSDT box to issue an EPSDT SAR. The SAR # will begin in "91." Provider must bill manually. Check the NL 03-0205 for specific instructions.
Common CCS EPSDT Benefits	Hearing Aids, This Computes! 363 Speech and Language Therapy, Numbered Letter 15-0605 Private Duty Nursing, This Computes! 322 Non-covered diabetic supplies This Computes can be found in CMSNet Bulletins.
Speech and Language	Refer to Numbered Letter 15-065 for complete details https://www.dhcs.ca.gov/services/ccs/Documents/ccsnl150605.pdf The following is from section F.II in the NL: Speech pathology services, when requested by an Outpatient Rehabilitation Center, can be authorized as regular Medi-Cal benefits. When done at other sites, they must be authorized as EPSDT for clients with full scope, no share of cost Medi-Cal.
PDN SARs for Home Health Services Providers	EPSDT and CCS Eligible information see DHCS Information Notice 18-03 Skilled Nursing SARs using G0300: Skilled Nursing LPN G0162: Home Health Assessment require EPSDT approval

Example of creating a PDN EPSDT SAR



Code	Type	Description
G0300	1 N T	INSERT REPOSIT LEAD DUAL+GEN
G0300	1 N T	HHS/HOSPICE OF LPN EA 15 MIN
G0300	1 N T	SKILLED NURS LPN, HH/HSPC PER 15MIN

Code	Type	Description
G0299	1 N T	INSER/REPOS SINGLE ICD+LEADS
G0299	1 N T	HHS/HOSPICE OF RN EA 15 MIN
G0299	1 N T	SKILLED NURS RN HH/HSPC EACH 15MINS

Code	Type	Description
G0162	N 1 T	HHC RN E&M PLAN SVS, 15 MIN
G0162	N 1 T	SKILLED SVC RN MGT EVAL/PLAN PER 15MIN

Using MEDS for Coverage Information	
MEDS Screen	**Information Found on Screen**
HE	CCS Aid Codes: 9K – CCS Only; M/C with signed PSA on file; M/C with SOC 9R – TLICP over 40K 9U – TLICP with income unknown 9N – M/C only—no signed PSA on file 9M—MTP only
QM, Q1 or Q2	Medi-Cal eligibility status –The aid code definitions can be found in the Aid Codes Master Chart. The codes will tell you what type of M/C the client has such as OTLICP, Emergency Only or full scope Medi-Cal. A client may have different types of eligibility on different screens. For CCS billing purposes, full scope Medi-Cal trumps all. **Note:** The Aid Codes Master Chart is managed by DHCS. You must have a MEDS Home Page Account, issued to you by DHCS, to access it. Your county's Department of Human Assistance may post a link to the documents or there may be one or two individuals in your county who have access to this account. It is advisable you find the link or the individuals and request updated copies of the Meds Network User Manual and Master Aid Code chart periodically.
QX –SSI/DDS	SSI Status | Eligibility code 60 • indicated cash benefit • client receives cash to augment medical costs not covered by M/C (as in non-formulary drugs not payable with an override)
Q7	Past History – good for solving denials less than 24 months old when eligibility is the issue. • See ACSNet manual for 37 month history
HI	View Insurance Plan data
MOPI	Shift F12; BIC: enter date or date range: This is what providers see when they run eligibility for a client. CCS case should say 'may be CCS eligible'. Will have account numbers and phone numbers for OHC plans. **Note:** Errors in insurance information must be corrected by the family.
XB	BIC Issue Number and Date: From QM screen, type XB in Options. The BIC screen will populate.
INQN	Fuzzy Screen: Used to look up a client when information is missing

Part II – Authorizing Services

Information and Tips to Prevent Denials

Part II – Authorizing Services

Information and Tips to Prevent Denials

Know Your SARs and Service Code Groups (SCGs)	
SARS For a complete SAR overview, go to the Medi-Cal Provider website, and type "cal child sar" in the search field.	Service Authorization Request (SAR)—The form submitted by a provider to the CCS County office when requesting authorization for services. The term "SAR" is also commonly used to refer to the actual authorization given to the provider in response to their request. SAR Overview
SAR Tools	https://www.dhcs.ca.gov/services/ccs/cmsnet/Pages/SARTools.aspx
Service Code Groups—Groups of HCPCS codes that authorize a provider to render any of the services included in the group. To find an updated list, go to the Medi-Cal Provider web-site, and type "calchildser" in the search field.	SCG 01 – Physician (covers office visits, x-rays, MRIs, EEGs, Cat Scans, lab work) SCG 02 – General Special Care Centers (includes all codes in the 01) SCG 03 – Transplants Special Care Centers (Includes 01 & 02) SCG 04 – Communication Disorder Centers (Audiology) SCG 05 – Cochlear Implant Centers (Includes 04) SCG 06 – High Risk Infant Follow-Up SCG 07 – Orthopedic (Includes 01, covers most fracture repair codes) SCG 08 – Rural Health/Federally Qualified Health Clinics SCG 09 – Chronic Outpatient Dialysis Clinic (Need to add SCG 01 also) SCG 10 – Ophthalmologic Surgery (Need to add SCG 01 also) SCG 11 – Medical Therapy (OT & PT coding) SCG 12 – Podiatry SCG 51 – Surgery SAR, Exclude SCG (the codes listed are excluded). NL 02-0510

Inpatient and Out-Patient SARs	
Facility/Hospital SAR (Inpatient SAR)	• Inpatient SAR pays for days and bed only. • Issued to the Hospital. • No codes or SCGs are added to an Inpatient SAR. • Physicians/ancillary services cannot bill with an Inpatient SAR. • Physicians will need a SCG 01, 02, 04, etc, SAR to bill for services during I/P stay. • At Private Hospitals, SAR is issued for 1 day for Diagnosis Related Group (DRG) payment. See This Computes! 424, 426, 430, 440, 442 ◦ Find This Computes in CMSNet under Bulletins • As of 1/2/15 CCS covers the entire stay at Designated Public Hospitals if child was only CCS medically eligible for part of the stay. Numbered Letter 04- 0715.
DRG SARs	For more information on DRG SAR follow the link: https://www.dhcs.ca.gov/provgovpart/pages/drg.aspx

Physician SAR (01)	• Issued to one physician only.
	• Physician is required to share with other providers.
	• Ancillary services of an I/P stay can bill using the 01 SAR. Examples:
	  ➢ Labs
	  ➢ Radiology
	  ➢ Therapy
	  ➢ Consults
	• Physicians can also bill with 02 if available when there is only a facility SAR for an Inpatient stay.
	• Physician can share SARs with other physicians for billing purposes

Special Care Center (SCC) SAR (02)	• All providers can bill using a 02 SAR. • Hospitals holding 02 are required to share with other providers. • CCS will fax copy to a different hospital. • Doctor does not need to be registered to Center to bill when using an 02 SAR • Ancillary providers can bill with 02 SAR. • Special Care Center Directory
Transplant SAR (03)	• Draft In progress

Dialysis SAR (09)	• Draft in Progress
Out-Patient Facility SAR	• Out-Patient facility can bill with physician's SAR • Physician must share w/facility • Physician named on the SAR is the 'referring provider' for Out-Patient billing • The 01 SAR should include any anticipated procedure codes not already included in 01. • ER visits not resulting in an I/P – The facility can bill with the 01/02 SAR
Emergency Transport	Requires its own SAR
Cochlear Implant	L8614 must be on Out-Patient SAR. NL 03-0411, 5
Non-PMF provider	Issue the SAR to the facility when using a Non-PMF provider. Cannot issue a SAR to the non-PMF provider directly. Depending on the provider type, the Non-PMF provider will be CCS paneled (if they are a physician), or will be linked to a CCS approved facility (such as a PT/OT/LVN/orthotist)
Out of State Hospital	CCS can authorize to an out of state hospital provided the hospital is registered as a Medi-Cal provider. A CCS In-Patient SAR will cover the facility but we are not able to authorize the non-paneled physicians. Most Medi-Cal hospital providers know this and make internal adjustments for the physicians and ancillary staff. Refer questions from the hospital to the Provider Enrollment Division Or call they can call 916-636-1200.: It the hospital is not a Medi-Cal provider, they can legally bill the CCS client directly. This also includes the non-Medi-Cal physicians. It is advisable to let CCS families know they could face medical bills when traveling if the hospital/physicians they see are not Medi-Cal providers.

ISCD SAR Cover Sheet	Local CCS county programs use this cover sheet when sending requests to ISCD for the following reasons:
	• Independent Classic County—ISCD approves SARs for transplants, Cochlear Implant Surgery, out-of-State requests, Zolgensma and initial requests for Spinraza.
	• Dependent Classic County—Same as Independent Classic county, plus authorization requests (based on CMIP level), and initial eligibility and annual review.
	• Independent WCM County—
	  ○ For child enrolled in the Medi-Cal Managed Care Plan: any requests for clotting factor and Hemlibra that are submitted with a procedure code (if submitted with an NDC code, the provider/pharmacy will send the request to Magellan)
	  ○ For CCS-only or child with FFS Medi-Cal: same as Independent Classic County.
	• Dependent WCM County—same as first bullet for Independent WCM County, plus any requests related to initial eligibility or annual review, plus any authorization requests for eligible children not enrolled in the Medi-Cal Managed Care Plan (CCS-only or FFS).
	
	Check Numbered Letters for policies and instructions related to specific items listed above.

Pharmacy SARs	
Medi-Cal Rx: Transition to Magellan	Magellan takes over as the pharmacy authority for Medi-Cal on January 1, 2021. Most pharmacy authorizations will be issued by Magellan. Specifically, all pharmacy products billed with a NDC code. CCS will continue to authorize pharmacy related products billed as a medical or institutional claim.
Medical Supplies	Limited supplies may be covered under a 01 or 02 SAR. Medical Supplies are never covered on an 08 SAR.
Albumin Test Strips	Albumin is a medical benefit, and not a pharmacy benefit. It is authorized with a T5999 SAR and has to be submitted as a manual claim.
For pharmacy inquiries, contact CMS Branch Pharmacy Consultant Kirstie Yi at Kirstie.yi@dhcs.ca.gov or (916)704-8724. For medical inquires, contact Dr. Jill Abramson via e-mail at Jill.Abramson@dhcs.ca.gov or telephone at (916)327-2108 for questions.	

Tip: an incorrect configuration of units and quantity can result in denials.

- **If the SAR configuration is correct and provider is still getting denied, verify:**
  - **Provider is using the code which is on the SAR**
  - **In ACSNet, verify there are still units available on the SAR**
  - **The second step would be to research the code or NDC in ACSNet**
    - **Verify Units Used**
    - **TAR Status**

Diabetic Supplies		
For the most up to date list of covered benefits, refer to the Covered Products Lists on the Medi-Cal Rx website and Medical Supplies Billing Codes, Units and Quantity Limits.		
	Authorized by CCS	**Authorized by Medi-Cal Rx**
Continuous Glucose Monitor (CGM) Systems • Therapeutic and Non-Therapeutic	**No**	**Yes** Please refer to the list of covered benefits linked to the left.
Home Blood Glucose Monitors **Self-Monitoring Blood Glucose Systems (Glucometers)**	**No**	**Yes**
Insulin Pumps	**No** Disposable Insulin Delivery Device (DIDD) (i.e. V-Go, Omnipod)	**Yes** V-Go, Omnipod, and Omnipod Dash
	Yes All other Insulin Pumps that are not covered by Medi-Cal Rx	
Pen Needles	**No**	**Yes**
Blood Ketone Test or Reagent Strip	**No**	**Yes**

DME-R SARs	
CCS NL 09-0703	CCS Guidelines for Recommendation and Authorization of Durable Medical Equipment – Rehabilitation (DME-R)—everything you need to know about authorizing DME.
Modifiers	A DME authorization will not pay if the modifier is missing. RR – rental equipment NU – New purchased equipment RP – equipment repair RB – labor
Vests – E0483	Rental only: expensive product, changes often, goes back to provider when done with, rental less expensive over time.
DME Frequency Limits—search with "dura cd fre" on the Medi-Cal webpage. For orthotics and Prosthetics, seach with "ortho cd fre1"	Frequency restrictions are applied to procedure billing codes within the designated timeframe. Frequency limits can be overridden (with the exception of diabetic shoe and insert codes) if the CCS paneled specialist provides a letter of medical necessity.
DME Billing	DME and medical supplies requires billing with invoices AND catalogue pages Provider must bill manually and include invoices (regardless of pricing)
Pricing not on file	When the pricing is not on file, the reimbursement rate for the code may be 'under review' or not yet submitted to MC for review. The provider must bill with current catalogue page (Med supplies/DME) copies to establish the reimbursement rate.

Telehealth SAR Information	
Telehealth Basics and Policy and Procedure Links	Telehealth is a process for delivering health care to individuals virtually from a distance. This can include Rural Health Centers (RHC) and Indian Health Services. The process is available to CCS providers • CCS MTU: initial assessment must be done physically, thereafter treatment can be provided virtually. • Providers must use Place of service code 02 on claims • Use modifier 95 when billing for synchronous (real time) appointments with the patient • Use modifier GQ for asynchronous transmission of patient records when the patient is not present (also used for E-consults with the service providing care for the patient) • E-consults are used to assist in diagnosis and case management between physicians Here are some links to Telehealth documentation in the Medi-Cal Manual: Telehealth policy, codes and billing requirements. Telehealth relative to Covid-19 Telehealth relative to Auditory Rehabilitation Telehealth Definitions This Computes: codes included in Telehealth billing: Found in CMSNet Bulletins (top right corner of CMSNet Home Page).

Miscellaneous SAR Information	
Diagnostic SARs for children with OTLICP ThisComputes #467	CMSNet does not have the functionality to designate services as "diagnostic" for a beneficiary with OTLICP. If "diagnostic" is selected on the SAR, the charges incorrectly default to the CCS-only diagnostic funding category on the MR-0-940. To avoid this, OTLICP SARs should be authorized as "treatment." Use special instructions to explain that the SAR is for diagnostic purposes only, and be sure to limit the SAR to 90 days (there may be certain exceptions beyond the 90 days). Checking medical reports during the diagnostic work up will ensure that the SAR can be canceled timely if the child is found to be not treatment eligible.
By Report	This designation in Medi-Cal means the code requires its own SAR. • Go to Medi-Cal website, then Provider Manual • Enter the HCPCS in the search window • Select the most likely result and check if By Report, or By Report Not Specified By Report Link: CMS 1500 Billing https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/cmsspec.pdf By Report DME Billing: https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/durabil.pdf
By Report Not Specified	This designation means the requested item or service can be billed with an 01 or 02 SAR. See above "By Report" for instructions on finding the item's designation. However, the provider must attach the required reports. Billers will understand this language and will know which reports to attach.
Modify SAR begin date	SAR begin date can be made earlier as long as it is within the program eligibility period. A SAR cannot be modified to reduce time.
SAR extensions	SARs can be extended for up to 2 years before a new SAR must to be issued.
Canceled SAR	Codes cannot be added to a canceled SAR. A canceled SAR can still be used to bill for services during the effective dates on the SAR.
Dental CPT code 41899	If a provider requests 41899, add this code to a facility 01 SAR. Only authorize if the procedure is to be performed by an MD, not a DDS.

Procedure Types Go to the Manuals link at the upper right corner of the CMSNet website, choose the Procedure Code Inquiry Manual.	Sometimes when generating a SAR the system will force you to select a Procedure Type (often J, K, or I). Use this list to help you decide which letter to check: E = Local Education Agency F = EAPC G = AIDS Waiver I = Injection J = Anesthesia K = Primary Surgeon L = Radiology M = Pathology and Clinical Laboratory N = Medicine O = Assistant Surgeon P = Podiatrist 1 = Allied Health and other programs 3 = Vision Care
Pend/Deny Indicators - Go to the Manuals link at the upper right corner of the CMSNet website, choose the Procedure Code Inquiry Manual.	O – Default-no suspension or denial is applicable P – Pend for Medical Review S – Suspend if billed amount is over calculated file Price D – Deny claim. Not a covered benefit T – Deny Claim. Obsolete Code M – Manual Review R – X – Over Correlation Procedure only U – The code will not be subjected to the automated MAX UVS cutback. U codes will pay, but at a lower rate. The provider can chose to use another code.
R codes vs T codes	R codes are Restricted. They are payable but will require the biller to include invoices or medical justification. T codes are Terminated and are no longer payable by MC. When creating the SAR, select the R code line if the selection is only T or R. Codes with a 0 are payable without restriction.

Provider Types	Provider types refers to the Providers Specialty: 03 Audiologist 14 Home Health 16 Community Inpatient Hospital 17 Community Outpatient Hospital 19 Occupational Therapist 22 Physician Group 24 Pharmacy 25 Physical Therapist 26 Physician (with psychiatry/neurology specialty) 30 Ground Transportation 31 Psychologist 45 Physician Group 80 MTU Doctor
Category of Service	Related to Service Code Groupings and are designations given in Medi-Cal for the type of codes a Provider Type can bill for.

Common SAR Mistakes
• Modifiers are missing from DME SARs • Unit / Quantity is missing or incorrect. See This Computes! 329 • In-Patient stay End Date is extended on Non-DRG SAR, but number of days is not recalculated. • SAR End Date is extended but Unit/Quantity is not increased. • EPSDT SAR is issued as a regular SAR. EPSDT SARs must begin with 91. • R and T codes: Restricted (R) codes are ok to use, but biller must submit with medical justification. Terminated (T) codes are no longer eligible for use. • CGM – not creating a separate SAR for each component

Paneling Guidelines	
Web site link to Paneling Desk	Link to application for paneling. Electronic process is quick and can be completed in a few days. Paneling Desk Web Page This page contains paneling guidelines as well as a link to the application Note: the provider must be enrolled in Medi-Cal before becoming paneled. The Provider Enrollment Division will assist the provider in enrolling.
Paneling Desk Address & Phone Number	Children's Medical Services Branch Provider Relations Unit 916-552-9105 providerpaneling@dhcs.ca.gov
DME Providers	Do Not Require paneling. Do require Medi-Cal license
Therapists	Non-Provider Master File (PMF) Provider – Use Allied Application. **Cannot issue SAR to a Non-PMF**

Paneled Non-PMF Providers	This category includes Audiologists, Orthoptists', Occupational Therapists, Speech Therapists, Psychologists, Dieticians, and Social Workers. SAR cannot be issued in the Provider's Name. It must be issued to the Center/Facility. Once the SAR is created there is a field for CCS staff to enter the name of the Paneled Non-PMF Provider.
Retro Paneling	• New CCS doctor is paneled. • Paneling date is issued by State for date of application • Doctor saw child before paneling date CCS must send email to paneling desk requesting Retro Paneling.
Temp Paneling	• Issued for 3 years. • Is awarded to physicians who have not yet become Board Certified • Board Certifications submitted to Paneling Desk will result in permanent paneling • Failure to submit certifications will result in termination of paneling status at 3 year deadline • Termination of paneling will forfeit M/C payments from date of termination • Physician must re-apply and submit Certifications to become paneled and allow M/C payment to resume
Nurse Practitioners	Cannot be paneled. • Issue SAR to supervising physician. • NPI in 24J of CMS-1500 • Non physician name and NPI in box 19 of CMS-1500

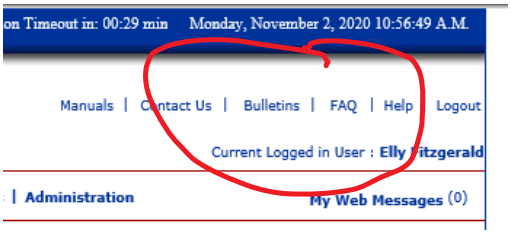
Paneling and ER Visits	
ER Visit – No Admission	Paneling is not an issue for treatment in an ER. An Out-Patient SAR will cover the facility, doctors and treatments. Billing with an O/P SAR does not require the physician's NPI.
ER Visit – Results in Admission	The Admitting/Attending must be CCS paneled. Non-paneled admitting/attending will result in a denial of the I/P stay and all billing by ancillary staff and services (physicians, labs, radiology, etc.)

Part III – Claim Denial Troubleshooting

Information and Tips to Help Providers Resolve Denied Claims

Part III – Claim Denial Troubleshooting

Information and Tips to Help Providers Resolve Denied Claims

How to Use the SAR to get paid – search "CCS Claim Completion" on the Medi-Cal website for more information and Samples	
CMS-1500	• SAR # must be in Box 23 • Pharmacy uses this form if billing with a HCPCS • Ancillary providers and out-patient facilities, MDs, etc. can bill with 01 SAR by adding the referring physician in box 17b. The referring physician for this purpose is the physician that the SAR is issued to. • The physician whose name and NPI are on the SAR **must** be on the claim. If another physician is using it, the SAR owner must be listed as the Referring Physician, regardless if that physician made the referral or not. • For Non-physician billing, enter the NPI of the MD on the SAR in Box 24J, it is not necessary to enter the non-physician name and NPI on the SAR.
UB-04	• SAR # must be in Box 63 • Ancillary providers can bill with 01 SAR by adding the referring physician in box 76. The referring physician for this purpose is the physician that the SAR is issued to. • Remember –the name and NPI of the physician on the SAR **must** be on the billing.
Numbered Letters	For detailed information on policy changes effecting SAR creation and denial reasons see Number Letters on the DHCS web site.
This Computes! and Bulletins	This Computes! (TC!) and Bulletins are a good resource for researching SAR problems and denials They can be found in CMSNet. From the Home Page, select Bulletins in the top right corner:  Inside you will find a link to the TC! Archive and a listing of Bulletins.

Common Denials and Solutions		
Denial Type	**Possible Reason**	**Possible Solution**
CCS eligible Bill to other processor Bill GMC or OHC	If the County is a classic CCS County, biller submitted claim to the managed care plan instead of to Medi-Cal	Ask biller if they submitted the claim to [*enter county managed care name*] or to the Medi-Cal Fiscal Intermediary They need to submit the bill to the Medi-Cal Fiscal Intermediary. **Mail manual claims to:** **PO Box 15700** **Sacramento, 95852-1700.** Advise the biller to enter the SAR # in Box 23 of the CMS-1500 form or Box 63 of the UB- 04.
Client not eligible	• Provider is attempting to bill electronically using the SAR on the day it was issued • Provider is not using the same BIC number as on the SAR (could be a duplicate M/C case requiring merger • Provider needs correct BIC issue date • M/C is expired for month of service	• Ask provider to wait until the next day. The SAR has to upload to the State server before the system can "find" it. • Verify provider is using correct full BIC # (look up using instructions in the MEDS manual) • Verify provider has the correct Issue Date (this is the reason clients must provide their BIC card. Provider must be able to run it for updated M/C information • SAR is not payable if M/C expired. It is the provider's responsibility to run the BIC card. If they supply service/product first, there is no guarantee of payment. Clients can have a new card in less than 2 weeks by calling the CCS office and requesting a new card.
Physician provider states "We always get paid with that SAR"	• SAR may have expired, or provider might be billing for a code that isn't on SAR • BIC issue date may have changed.	Check date range on SAR. If it's a 01 or 02 SAR, make sure the code they are billing for is included in the SCG. Check MEDS and give the new date. (Instructions in the MEDS Manual for finding full BIC # and issue date.) • **TIP:** Advise the provider to ALWAYS run the BIC card. It the client does not have one CCS can order a new one. (CMS Net, Program Modules, Replace BIC)

Common Denials and Solutions by RAD Code		
RAD Code Table	**The new RAD Code Table has both manual and electronic billing denial codes in one document. Open the link below then go to the hyperlink Remittance Advice Details to open the table.**	
RAD Codes do not always make the denial reason clear. Some of the more common denials seen by CCS are below. They point to possible solutions to the denial.		
RAD Code	**Possible Reason**	**Possible Solution**
005	Provider says service is not authorized by CCS. Why not?	SAR # was not entered. SAR was just entered or modified – wait 24 hours for SAR to upload to M/C
007	Missing or invalid cardholder id.	Verify correct ID (BIC) is being used. Go to MEDS and get current BIC issue date and full BIC # with the 5 digits after the alpha digit. (See MEDS Manual for how to do this or type XB from the QM Screen).
10	Previously Paid	If denial is within 12 week window, find it in ACSNet and give the provider the Warrant # and Date of payment
036	RTD not submitted	RTD – Return Turnaround Document. MC will send these to billers to make a correction in a hardcopy claim. Returning it will avoid rebilling. Advise provider to find RTD to determine denial reason of original claim. If not able to locate, rebill claim. Benefit of returning the RTD is that it keeps the claim timely (provided RTD is returned timely)
9942	Quantity billed is greater than allowed: V5298 (Hearing Aid)	Can bill for one unit only. Invoice must document 2 units and provider will be paid for 2 units.
031	Provider not eligible for DOS	Check CMSNet Provider's file. Was provider paneled on DOS Was provider Category of Service (COS) correct for DOS (may need to contact CMSHelp to determine provider's eligibility to bill for the code.

0037	Capitated service not billable to M/C	CIN number not on claim Or client has fallen off M/C – check eligibility. If eligibility is ok – CIN # is probably not on claim. Or, child's Medi-Cal may be from a carved-in county if they recently moved. Client needs to correct this.
0603	Pending Fiscal Intermediary Review	Provider should call the Help Desk (800-541-5555) with the Claim Control Number (CCN). If the rep is not able to help, encourage the provider to ask to speak to a supervisor, or to have their regional rep contact them. This is a common RAD code with Z5999 claims.
Note: In lieu of referring the provider to the Medi-Help desk, refer them to your local Medi-Cal field agent. Or contact the field agent directly for the provider. You will need the CCN number for the denial. The CCN is a unique number assigned to all transactions in the Medi-Cal payment system. Providers and county staff can call the telephone service center at 1-800-541-5555 and request a call back from the Medi-Cal field agent. CCN = Claim Control Number		

Issues Related to Coverage—Check MEDS		
Denial Type	**Possible Reason**	**Possible Solution**
Bill other insurer	Provider doesn't have other insurance info	View Insurance - HI HI screen will give insurer/phone number/start & stop date Or View Insurance - MOPI (Sometimes has more detailed info than HI screen) In MEDS - Shift F12 M Enter
Bill other insurer	Sometimes OHC is added without the knowledge of the client (as in absentee non-custodial parent getting coverage). Sometimes the parent forgets to notify CCS of addition of HMO/PPO.	If client does have OHC showing in Medi-Cal but they do not believe it is accurate, it is the client's responsibility to contact Medi-Cal to have any corrections made. Client is responsible for contacting CCS with any new OHC policy additions.
Bill other insurer (but MEDS is not showing OHC)	Possible scenario FOC/MOC is buying insurance per court order and custodial parent does not know.	Advise the provider to bill Primary Ins to see if there is a valid policy. If policy is not valid the custodial parent MUST get the OHC removed from case before any claims will pay.
No Eligibility	BIC Issue Date	This is a common denial reason for 'no eligibility'. Check that the provider has the correct **BIC issue date** (Some provider's proprietary software requires entry of issue date – not all do) In MEDS QM screen, select XB
No Eligibility	Adopted	Case will have 04 eligibility code; Check for incorrect CINs (provider could be billing with original CIN). Make sure the CIN on the SAR is the new CIN, not the original. An adopted child's CIN is never merged to the new CIN for confidentiality purposes. Use the new CIN. **Never share the pre-adoption CIN**

No Eligibility	Newborn	Should pay w/ mom's M/C for month of and month after birth. Check MEDS for Mom's CIN and give to biller. This will not match the CIN on the SAR. On CMS-1500 form, provider should enter "Newborn infant using mother's ID" in Box 19. If submitting electronically, enter statement in the ASCX12N837 Note Segment: Newborn Infant using mother's ID. This information must be added to Special Instructions in the SAR.

Scenarios in which ACSNET is a Resource		
Denial Type	**Possible Reason**	**Possible Solution**
No Eligibility	• Incorrect CIN • Incorrect BIC Issue • Client has no active MEDS for month of service	• Is provider using the CIN on the SAR. Use CalPOS (ACSNet) • Does the provider have the correct **BIC issue date** (if the provider's proprietary software requires entry of issue date – not all do)
No Authorization	• Units have been used • SAR is expired	• Check ACSNet for Units Used • If units have been used determine if more units should be added to SAR • Check SAR effective dates • Is a new request required or can SAR be adjusted
Previously Paid	• Claim was already paid.	• If denial is within 12 week window, find it in ACSNet and give the provider the Warrant # and date of payment. • If outside the 12-week window the provider will need to contact MC for payment details
Item/Product not covered	• Item must be billed manually.	• Verify correct SAR is being used • Provider is trying to bill item not covered by Medi-Cal. Provider must select a covered item • Provider must bill to Medi-Cal or OHC
Requires Prior Auth	• Incorrect SAR #	Check ACS Net for: • Correct SAR • Over units limit for the month

Exceeds Limit	• Units on SAR have all been used	• Determine if units need to be added to the SAR or a new SAR must be issued • MC has strict refill timelines. Provider may need to wait until the prescription is eligible for refill **Note**: Clients may try to fill multiple prescription when a vacation is planned. There is no work around for this.

Part IV – Client Gets a Bill

Information and Tips to Help the Client when Client gets a Bill in the Mail

Part IV – Client Gets a Bill

Information and Tips to Help the Client when Client gets a Bill in the Mail

Note: these instructions are not for pharmacy bills that should have been covered by Magellan

The following steps are Humboldt County's procedure for handling these claims. Some steps may be different depending on your county's practices.

1. Inspect bill for client's name, DOS (Date of Service), and medical provider.
2. Look in CMS and check:
   - Is this the first time we have taken action on this particular bill?
   - Check client's status with CCS on the Date of Service.
   - Double check that their Medi-Cal was active on the date of service.
   - If they have OTLICP, check to make sure it didn't lapse. Clients who turn 19 and have had OTLICP could be a problem, too.
3. Locate the SAR that will cover the service provided.
4. Contact the service provider's billing office and correct their information so they know:
   - To send the claim to ***Medi-Cal Fiscal Intermediary, PO Box 15700, Sacramento, CA 95852-1700.***
   - To enter SAR # in Box 23 of CMS-1500 (or Box 60 for UB-04).
   - If using a physician SAR, to enter the physician's name and NPI in Box 17 (or box 76 for UB-04).
   - If they already submitted a claim to the Medi-Cal Fiscal Intermediary and were denied, find out the denial reason. This will help troubleshoot so that the biller doesn't continue to repeat the same steps resulting in the same outcome.
   - The biller should be reminded that if a client has Medi-Cal on the date of service then the provider cannot hold the parent/client responsible for the bill. (If this becomes an on-going problem with a particular bill, you can cite the W & I code 14019. You can also give the parent/client the Sample Letter (attached) that they can re-create and send to the biller.
   - Tell the biller that if they have further problems with getting the claim paid, they should contact the Medi-Cal Help Desk at 800-541-5555. If that does not help, they should call CCS. Give them your phone number so they have it in their records. Make sure they will not send another bill to the family.
   - If the biller does not understand any of the above steps, ask to speak to their supervisor.
5. Contact Parent/Legal Guardian (or patient, if over 18) to inform them that we have instructed the biller on how to get their claim paid through CCS. Tell them to contact us immediately if they get another bill.
6. Write a description of the action taken in CMS case notes.
   - Choose the subject header "Bill/Claim Communication."
   - Enter the SAR # given to the provider.
   - Describe what the problem was that was preventing the claim from being paid, examples are:
     - Biller was submitting claim to Partnership instead of CCS
     - Biller didn't know to send claim to the Medi-Cal Fiscal Intermediary
     - Biller didn't have a SAR # and didn't know to put SAR in Box 23 of CMS

1500
    - Biller completed claim incorrectly for hospital using a physician's SAR
- Describe the action you took to help solve the problem with the biller.
- State that you contacted the parent/client to inform them of your actions.

7. Scan the bill and save it to the client's e-chart

California Welfare and Institutions Code Section 14019.4

(a) A provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or a person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.

(b) Whenever a service or set of services rendered to a Medi-Cal beneficiary results in the submission of a claim in excess of five hundred dollars ($500), and the beneficiary has given the provider proof of eligibility to receive the service or services, the provider shall issue the beneficiary a receipt to document that appropriate proof of eligibility has been provided. The form and content of those receipts shall be determined by the provider but shall be sufficient to comply with the intent of this subdivision. Nursing facilities and all categories of intermediate care facilities for the developmentally disabled are exempt from the requirements of this subdivision.

(c) In addition to being subject to applicable sanctions set forth in law or regulation, a provider of health care services who obtains a label from, or copy of, the Medi-Cal card or other proof of eligibility pursuant to this chapter, and who subsequently pursues reimbursement or payment for the cost of covered services from the beneficiary or fails to cease collection efforts against the beneficiary for covered services as required by subdivision (d), may be subject to a penalty, payable to the department, not to exceed three times the amount payable by the Medi-Cal program. In implementing this subdivision, mitigating circumstances, which include, but are not limited to, clerical error and good faith mistake, shall be considered when assessing the penalty. Providers subject to penalties under this subdivision shall have the right to appeal the assessed penalty, consistent with department procedures.

(d) When a Medi-Cal provider receives proof of a patient's Medi-Cal eligibility and that provider has previously referred an unpaid bill for services rendered to the patient to a debt collector, the Medi-Cal provider shall promptly notify the debt collector of the patient's Medi-Cal coverage, instruct the debt collector to cease collection efforts on the unpaid bill for the covered services, and notify the patient accordingly.

(e) If a patient provides proof of Medi-Cal eligibility to a debt collector, and the debt collector fails to notify the provider of this proof, the provider shall not be responsible for ensuring that collection efforts against the patient cease pursuant to subdivision (d) until either the patient or the debt collector provides the provider with proof of the patient's Medi-Cal eligibility.

(f) A Medi-Cal provider or debt collector shall be deemed to be in violation of subdivision (a) of Section 1785.25 of the Civil Code if more than 30 days after receiving proof of Medi-Cal coverage the provider or debt collector does either of the following:

(1) Furnishes information regarding the rendering of the Medi-Cal covered services to a consumer credit reporting agency.

(2) Fails to provide corrections of, or instructions to delete, as appropriate, information regarding Medi-Cal covered services previously furnished by that Medi-Cal provider or debt collector to a consumer reporting agency.

(g) This section shall not apply to the Medi-Cal share of cost owed by a Medi-Cal beneficiary, unless the beneficiary's share of cost has been met for the month in which services were rendered.

(h) For purposes of this section, "debt collector" includes any person who regularly engages in debt collection, as defined by Section 1788.2 of the Civil Code, but does not include the original Medi-Cal provider.

Sample Letter for Parent to Send to Biller

Your Name
Your Address
Your city, state, and zip code
Your phone number
Today's Date

TO: Name of provider of collection agency from your bill
Address of provider or collection agency from your bill
City, state, and zip code

RE: Name of person who received the services, the account number on the bill, date the patient received services

Dear Sir or Madam:

This letter is to inform you that I (or my child) had Medi-Cal coverage on the day these service were received. The Medi-Cal identification number is *The Medi-Cal ID Number from the card of the person who received services*, issued on *The issue date on the card*. The date of birth is *Date of birth of the person who received the services*. A copy of the Medi-Cal card is enclosed. Although I (or my child) have Medi-Cal and I provided the Medi-Cal card at the appointment, I have been billed for services I got from you. (See copies of bill(s), attached.) California Welfare and Institutions Code Section 14019.4 and 22 California Code of Regulations Section 51002 prohibits providers from attempting to obtain payment from a Medi-Cal beneficiary once the person provides proof of Medi-Cal eligibility. This letter serves to formally notify you that I have Medi-Cal. Therefore, I respectfully request that you stop all attempts to obtain payment from me and instead submit a claim for payment for the services I received to my Medi-Cal managed care plan or to the State Medi-Cal Fiscal Intermediary (Fiscal Intermediary).

You may submit a claim to Fiscal Intermediary
Fiscal Intermediary Medi-Cal Claims
P.O. Box 15700 Sacramento, CA 95852-1700

If you have questions about where to submit the claim, please call the Provider Support Center at 1-800-541-5555. Please send me written confirmation that the above account has been closed. Your prompt attention to this matter is greatly appreciated.

Sincerely,

(Sign your name here)

Print your name here

Part V – MTP Billing

MTC Billing Guide
PTR Billing Tip
Accessing PTR RADs and Financial Summaries

Part V: MTP Billing

Medical Therapy Conference Instructions for Completing and Submitting the CMS-1500 Claim Form

Before Completing the Claim

1. Record MTC Physician arrival and departure time on MTC Schedule.
2. Calculate total time to nearest interval per your county's specifications – 15 min, 30 min etc
3. Record any reimbursable mileage and/or meals and lodging receipts to the MTC Clinic/Consultation Form (see attached example)
4. Verify physician has signed the Clinic/Consultation Form
5. Save the completed and verified Clinic/Consultation Form, along with original receipts, as back-up for the claim.

The claim must be prepared on a CMS 1500 original claim form.

Form Completion

An original form must be used. A copy of a CMS 1500 form will deny. Forms can be ordered from most office supply stores.

Note: Periods/decimal points (.) cannot be used anywhere on the form. It is therefore important to have your printer aligned correctly to the form so that dollars and cents print into the correct fields on the form. The one exception to using a decimal point is in box 24g, (Days or Units box). For example, if the physician is billing for eight and half hours, enter 8.5

Tip: make copies of the form to use for printer alignment. Alternatively, you can carefully write in each box by hand with ink.

The box numbers below correspond to the numbered boxes on the 1500 form. All listed boxes are required for a claim to be paid. If a box # is not listed below, leave it blank.

Box # on CMS-1500 form	Box Title	Specific Instructions for completing the box
Box 1	Claim Type	Enter an X in the Medicaid checkbox
Box 2	Patient's Name	Enter the clinic's name. Example from Sacramento County: Bowling Green MTU
Box 3	DOB/Gender	The DOB must show an age under 21. It is helpful to select a DOB and use it consistently until it becomes 21 years old. Example of a DOB to use in 2020: 01/01/2010. Gender is discretionary, however it is advised you maintain consistency by using only one regularly.
Box 5	Address	Enter the address of the MTU

Box # on CMS-1500 form	Box Title	Specific Instructions for completing the box
Box 21	Diagnosis Code	Enter G809. For ICD Ind., enter 0.
Box 21 Example: 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. G809 B. C. D. E. F. G. H.		
Box 23	Prior Authorization Number	This is likely a Legacy Authorization, a number that has been 'grandfathered in' by Medi-Cal. An example from Sacramento County is Bowling Green MTU 34135495088 Verify your county's number. **Note:** Occasionally a claim will deny for Prior Authorization Required – when it does it is because the person reviewing the claim at the Fiscal Intermediary is not familiar with Legacy Authorization numbers. Try calling your Field Rep or the help desk at 800-541-5555 and follow the prompts to the CCS unit. They have the ability to resubmit the claim internally without you preparing a new claim.
Box 24a	Date of Service	Date of clinic consultation. Fill in From and To fields with same date. Never use slashes, dashes or periods. Example: 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY 02 15 17 02 15 17
Box 24b	Place of Service	In-person at the MTU – code 11 or 99. Either will work. Telehealth - 02
Box 24d	CPT/HCPCS and Modifier	For the CPT/HCPCS: Consultation/Clinic time - Z5422 Travel Time - Z5424 Meals & Lodging - Z5414 For the Modifier: Only enter if the appointment was telehealth – 95 Otherwise, leave the modifier box blank
Box 24f	$ Charges	Remember – you cannot insert decimals (.). The dollars and cents must align in their respective boxes.

Box # on CMS-1500 form	Box Title	Specific Instructions for completing the box
Box 24g	Units	This is the total hours. It is okay to use a decimal point in box 24g, (Days or Units box). For example, if the physician is billing for eight and half hours, enter 8.5
Box 24j	Rendering Provider	Enter the MTC physician's NPI #. This must be the same as the NPI # in box 33a.
Box 24 Line 2 or 3	Mileage	Code Z5424 A mileage unit is '1'. Enter number of mileage units in box g. A mileage unit pays $2.00. Mileage is one-way, less 10 miles (Box 24g)
Box 24 Next line	Lodging	Code Z5414 Keep receipt for your records. Do not include receipt with the claim form. Units = number of nights (Box 24g)
Box 28	Total Charge	Grand total of all charges
Box 31	Signature Block	All MC claim forms require an original ink signature. Do not use stamps. Signature of the MD is not required, but can be signed by the preparer. Do not extend your signature outside the box.
Box 33	Physician Info And address	The physician's name and billing address. Must use the 9 digit Zip Code Example 95926 2215 Remember no hyphens, slashes, dashes or periods
Box 33a	NPI number	This is for the physician's NPI. This must be the same as the Rendering Provider NPI # in box 24J. Note: the provider type has to be 080. You can find the provider type in ACSNet under type.

Finalize and Send

1. **Printing**—If using a printer, the printer must be aligned to print within the boxes on the CMS 1500.

   Tip: make copies of the form to use for alignment purposes. It could take several to get a proper alignment. Completing neatly by hand with ink will work, too.

2. **CCS Stamp—**A county stamp is required. This can be placed anywhere there is no claim data. County stamps should read: CCS Your County Name.
   Example:

   CCS Contra Costa County

This verifies that your county has reviewed and approves the submission of the form. A claim without the stamp might be denied.

3. **Send the Form**--Mail the form to:
   Medi-Cal Fiscal Intermediary
   PO Box 15700
   Sacramento, CA 95852-1700

   Send in a Manila envelope. Do not fold, staple, or paperclip. No back-up documentation is required. Special pre-addressed envelopes can be ordered from any place that supplies CMS forms.

Looking up Claim Status in ACSNet

The following process can be used to lookup claim status within the past 12 weeks in ACSNet.

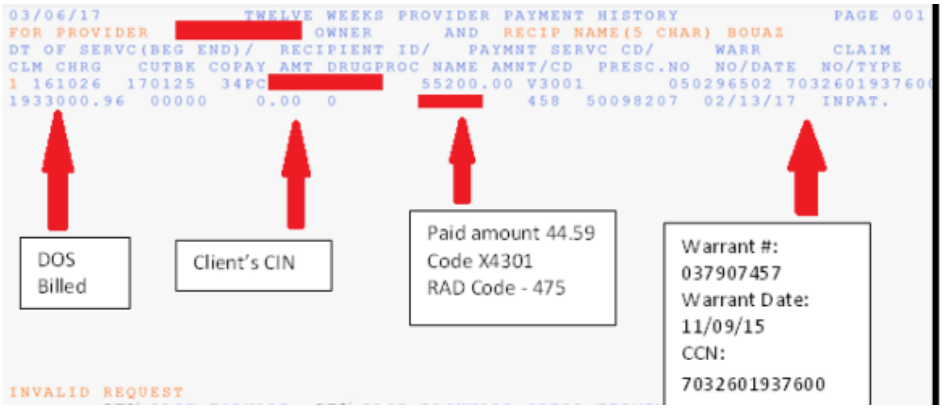
1. Log into ACSNet and select PF1 Provider Relations Subarea.
2. Select PF 6 Provider Subsystem.
3. There are a few options for looking up claim status. Enter Provider/MTU Doctor's NPI and select one of the following options:

   Option B: Beneficiaries CIN#

   Option D: Claims selected by date of service

   Option L: List all claims of providers. This option will allow you to lookup all claim information for one MTC provider within the past 12 weeks.

   Option N: Name of recipient or provider. This option will bring up all patients the provider has treated with the same last name. Be sure to verify the correct Medi-Cal #.
4. Hit Enter. Select PF3 to see adjudicated claims or PF2 for pended claims.
5. The screen will show 12 weeks of data including the date of serviced billed, client's CIN, paid amount, RAD code, warrant information, and claim control number. For details on RAD codes, refer to Common and Uncommon MTC Claim Denials or Medi-Cal RAD Codes.



For additional information, refer to the ACSNet Billing Manual Toolkit under "12 Week Payment History."

Common and Uncommon MTC Claim Denials

RAD Code	Denial Reason	Solution
0008	Provider of service is not eligible for type of services billed.	Look up NPI on ACSNET. Provider must be enrolled with Medi-Cal as Provider Type 080 and Categories of Service 099 and 777 to be paid for CCS MTC services. Refer provider to PAVE or PED Directory to seek enrollment assistance.
0010	Service is duplicate of previously paid claim.	Review records. If no payment is found, email Gainwell Technologies representatives for assistance. Include CCN, RAD and MTC claim.
0031	Provider was not eligible for services billed on date of service.	Refer to RAD code 0008.
0051	Signature is missing or is not original.	Sign inside box 31. Signature must be handwritten, not printed or stamped, using black ballpoint pen.
0053	Unable to process claim due to illegibility, incorrect format or attachment.	Refer to Billing Tips: Paper Claims on Medi-Cal website.
0062	Place of Service is not acceptable for this procedure.	Enter "11" or "99" in box 24B. Do not use any other place of service codes.
0628	Medi-Cal provider/recipient ID or service billed is not consistent with CCS authorization form.	Stamp header of MTC claim. If "CCS" is missing, handwrite or print "CCS" above stamped county name.
9124	Diagnosis code is missing or invalid.	Enter "G809" in box 21A. Do not use any other diagnosis codes.
9282	Patient sex code missing or invalid.	Enter "X" in M (MALE) field of box 3.
9981	ICD indicator is missing or invalid.	Enter "0" in ICD Ind field of box 21.

Notes on Denials

If MTC claim is denied, correct and resubmit MTC claim. Make corrections on new, original CMS-1500 claim form.

If MTC claim is suspended, either correct and resubmit MTC claim, or complete and return Resubmission Turnaround Document (RTD) by due date shown. RTD is faster way to expedite adjudication process but is not readily issued.

Regardless of CCS program models (independent, dependent or whole child), MTC claims are adjudicated by Gainwell Technologies on behalf of CA MMIS FI, expediently as possible but no later than 45 days.

Every adjudicated claim line is issued Remittance Advice Details (RAD) code, which can be found on Medi-Cal Financial Summary and ACSNET. Medi-Cal Financial Summary is often referred to as RAD. RAD codes, descriptions and billing tips can be downloaded in one Excel document, RAD Repository, on Medi-Cal website.

Do not delay timely submission of MTC claims. To receive 100% reimbursable rate, Gainwell Technologies must receive MTC claims within 6 months from month of service (MOS). If MOS falls after 6-month and before 12-month billing limit, enter delay reason code "3" in EMG field of box 24C.

Sample Consultation/Clinic Form

Provider's Full Name	Specialty	Funding Source
Provider's IRS/SSA Number	Date of Consultation/Clinic	Location of Consultation/Clinic
Provider's Complete Address		

Consultation/Clinic Time	Code	Item	Allowances	Charges	Subtotals
MD/DDS	Z5422	_____Hrs	@ $125.00	$_____	
Others	Z5408	_____Hrs	@ $38.00	$_____	
P & O Providers	Z9030	_____Hrs	@ $25.00	$_____	$_____
Travel Time (Use only for time not included in mileage allowance, e.g., air travel)					
MD/DDS	99082	_____Hrs	@ $50.40	$_____	
Others	Z5410	_____Hrs	@ $22.80	$_____	
Airplane (Attach Receipt)	99199			$_____	$_____
Mileage (One way, less ten miles) Mileage allowance includes professional time lost					
FROM:_ TO:__					
MD/DDS	Z5424	_____Miles	@ $2.00	$_____	
Others	Z5412	_____Miles	@ $1.70	$_____	
P & O Providers	X9032	_____Miles	@ $1.42	$_____	
Car Rental, Public Transportation Incl. Taxi (Attach Receipt)	99199			$_____	$_____
Meals Lodging, Etc.	Z5414				
Leave:	Date_____ Time_____				
Return:	Date_____ Time_____				
	Lodging (Attach Receipt)		@ $90.00 + tax Max	$_____	
	Breakfast		@ $ 7.00	$_____	
	Lunch		@ $11.00	$_____	
	Dinner		@ $23.00	$_____	
	Misc.		@ $ 6.00	$_____	$_____
	Parking, Tolls, Phone, etc. (Itemize)		Z5414	$_____	

Provider's Signature	Date	Total Claim
		$

PTR Billing Tip

PATIENT THERAPY RECORD

1-15 minutes = 1 unit
16-37 minutes = 2 units
38-52 minutes = 3 units
53-67 minutes = 4 units
68-82 minutes = 5 units
83-97 minutes = 6 units
98-112 minutes = 7 units
113-120 minutes = 8 units

"T"–Therapist not available:
(1) Ill
(2) Medical appointment with another child
(3) Meeting
(4) Other

"P"– Patient not available:
(1) Ill
(2) School cancelled
(3) Parent cancelled
(4) Failed appointment
(5) Holiday
(6) Other

S –Patient cooperation was:
(A) Good
(B) Fair
(C) Poor

O– Direct/Indirect

A –Response to treatment:
(A) Good
(B) Fair
(C) Poor

P– Plan:
(A) Continue
(B) Modify
(C) Re-evaluate

(1) MTU conference
(2) Private
(3) CCS special center

	Month: 1	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
	S:																																	
DIRECT	O: Treatment																																	A
DIRECT	Evaluation																																	B
DIRECT	Case Conference																																	C
	Field Visit																																	D
	Mileage																																	E
INDIRECT	Consultation																																	F
INDIRECT	Documentation																																	G
INDIRECT	Other																																	H
	A:																																	
	P:																																	

Do not enter "other" into the PTR in E-47. Doing so will prevent the entire month of all services from paying.

	Month: 2	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
	S:																																	
DIRECT	O: Treatment																																	A
DIRECT	Evaluation																																	B
DIRECT	Case Conference																																	C
	Field Visit																																	D
	Mileage																																	E
INDIRECT	Consultation																																	F
INDIRECT	Documentation																																	G
INDIRECT	Other																																	H
	A:																																	
	P:																																	

	Month: 3	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total	
	S:																																	
DIRECT	O: Treatment																																	A
DIRECT	Evaluation																																	B
DIRECT	Case Conference																																	C
	Field Visit																																	D
	Mileage																																	E
INDIRECT	Consultation																																	F
INDIRECT	Documentation																																	G
INDIRECT	Other																																	H
	A:																																	
	P:																																	

Signature(s)			Date	
☐ Physical Therapy ☐ Occupational Therapy	Treatment diagnosis 373.02 - SQUAMOUS BLEPHARITIS		Primary diagnosis 373.01 - ULCERATIVE BLEPHARITIS	
Patient Name TEST,CASE		Date of birth 08/01/2008	CIN 32563932A5	CCS number 3279884
Year 2010	Quarter 1	Medical direction KAISER	County of legal residence Imperial	MTU and county number ONTARIO MTU 13
Therapy D/C				

Accessing PTR RADs and Financial Summaries

<table>
<tr><th colspan="2">Accessing PTR RADS and Financial Summaries</th></tr>
<tr><td colspan="2">PTR Remittance Advice Details (RADS) and financial summaries are viewable using Medi-Cal Transaction Services on the Medi-Cal website: https://www.medi-cal.ca.gov/. PTR RADs are viewable by logging in with the MTU NPI and Provider Identification Number (PIN).</td></tr>
<tr><td>Network/Internet Agreement</td><td>To access Transaction Services, providers are required to fill out the Network/Internet Agreement.

Medi-Cal accepts this form electronically. Visit https://files.medi-cal.ca.gov/pubsdoco/signup.aspx and click on the blue hyperlink that says Electronic POS/Internet form.

Note: the address that you enter on the last page of the agreement must be the service address (not the pay-to address).</td></tr>
<tr><td>Provider Identification Number (PIN)</td><td>To obtain the PIN associated with a billing NPI number, contact the Telephone Service Center at 1-800-541-5555 and they will mail the PIN via USPS. The NPI and PIN are required to login to transaction services to view electronic RADs. Here is the phone tree to get to the right desk:

9 All Other Calls
1 English
1 Provider
4 Technical Help Desk
2 CMC
1 Provider
1 Enter NPI & #
1 Yes, Correct
1 CMC</td></tr>
<tr><td>RAD User Guide</td><td>User_Guide_PDF_RAD_Web_Portal.pdf</td></tr>
</table>

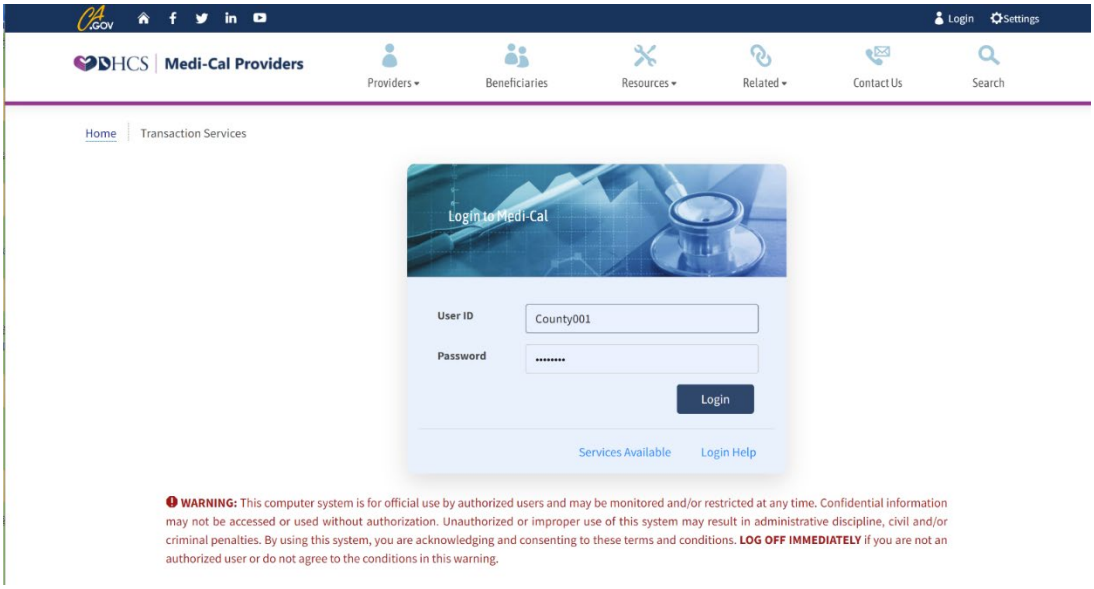
Part VI – MR-O-910 & MR-O-940s

Instructions for Downloading and formatting the report
Procedure for Reviewing
Procedure for Correcting Errors
Funding Source Cheat Sheet

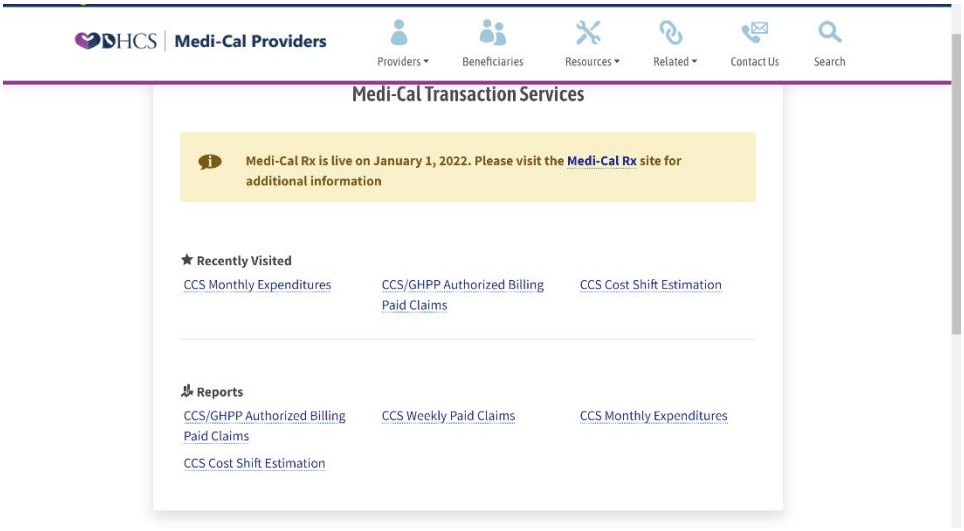
Part VI – MR-O-910 & MR-O-940s

Instructions for Downloading CCS Electronic MR-O-910 / MR-O-940 Reports

1. Login to the Medi-Cal website at: https://medi-cal.ca.gov/MCWebPub/Login.aspx. Contact Telephone Support Center at 1-800-541-5555 for assistance with login/password.

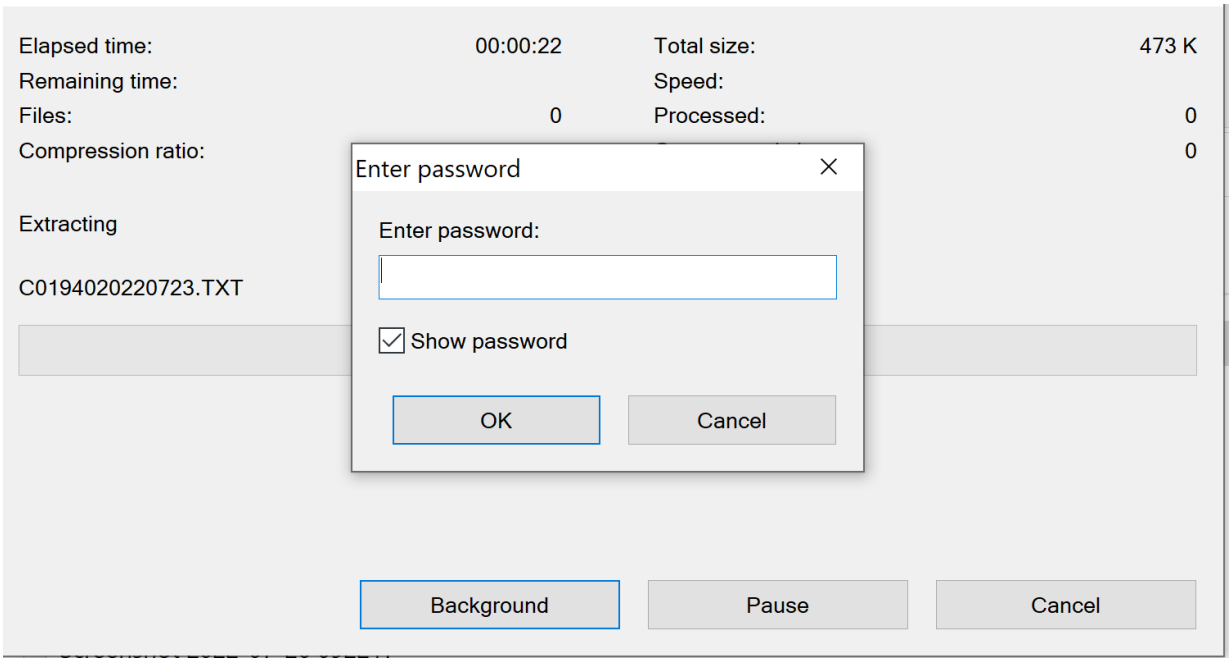


2. Select either CCS Monthly Expenditures (MR-0-940) or CCS Weekly Paid Claims (MR-0-910)



3. Select the date of the MRO940 report you would like to download.

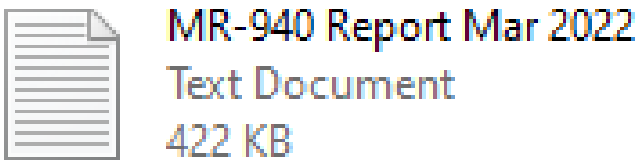
4. Designate the location where the unzipped document will be stored and enter your password again to unzip. Note: you must have WinZip, 7-Zip or other compression software to unzip the files.



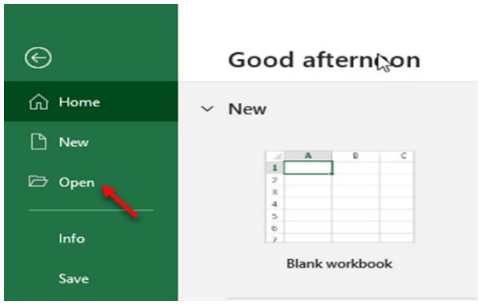
Converting MR-0-940 Report to an Excel File

Once you download the report from the Medi-Cal website, you can convert the document into an excel file to review the report using the following steps.

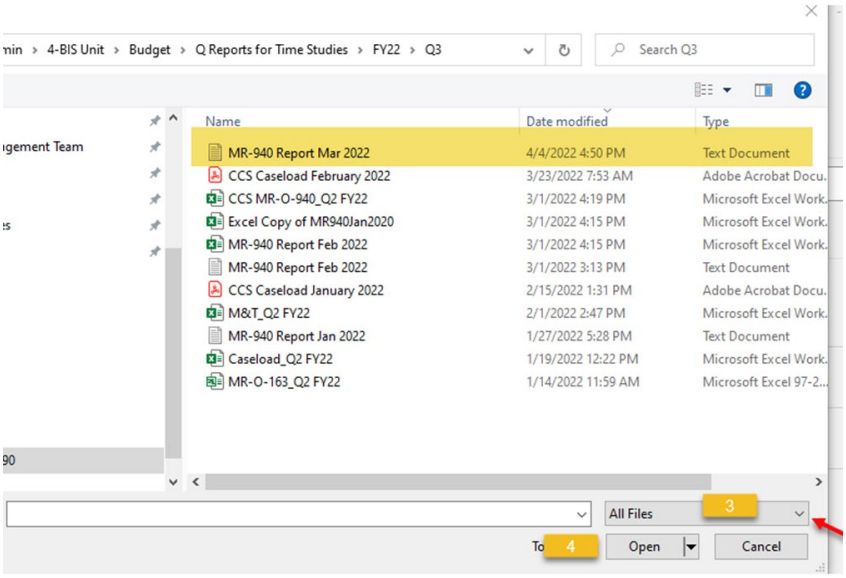
1. Save the Text Document into a designated Folder on your computer.



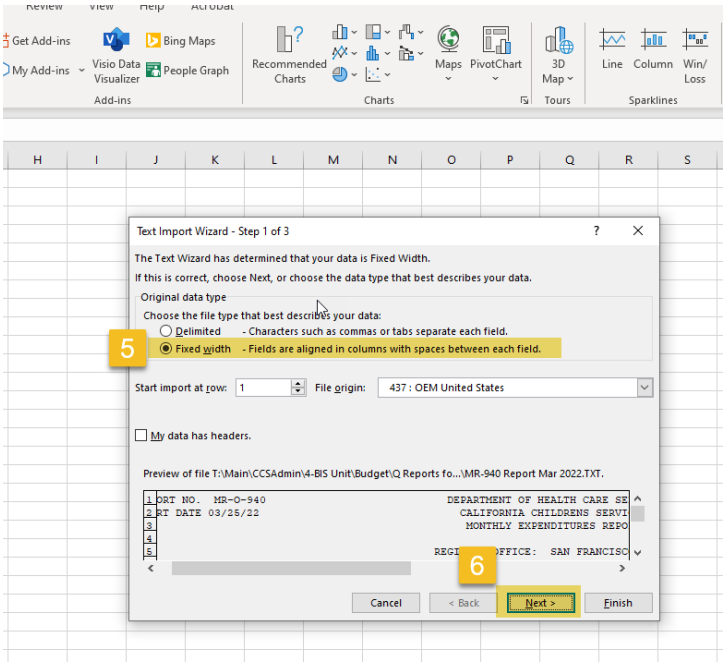
2. Open a Blank Excel Workbook, Click “Open” and find the Text Document saved on your computer.



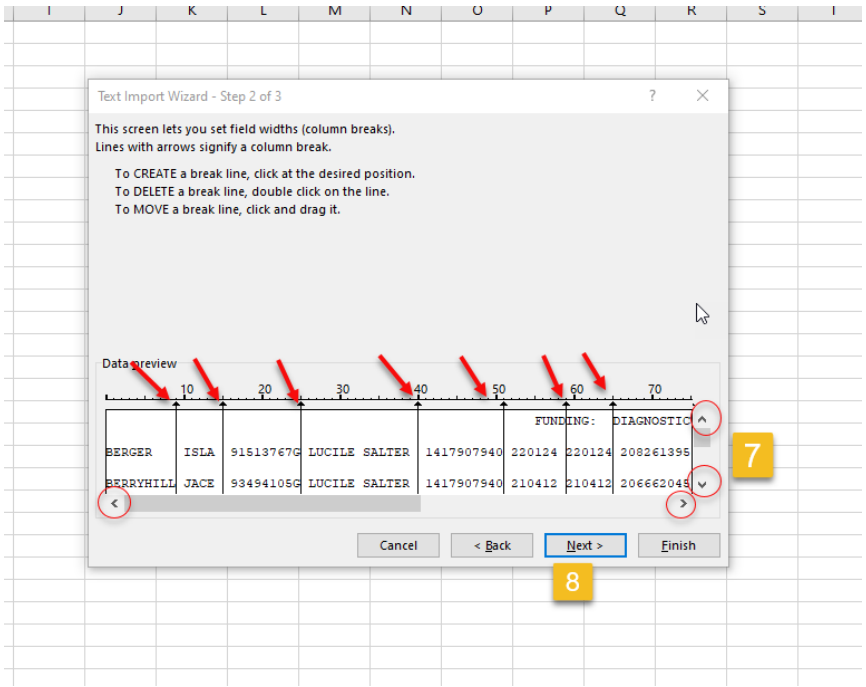
3. Find the Text Document in your designated folder by changing the file type to “All Files”.
4. Select the Text Document and Click “Open”.



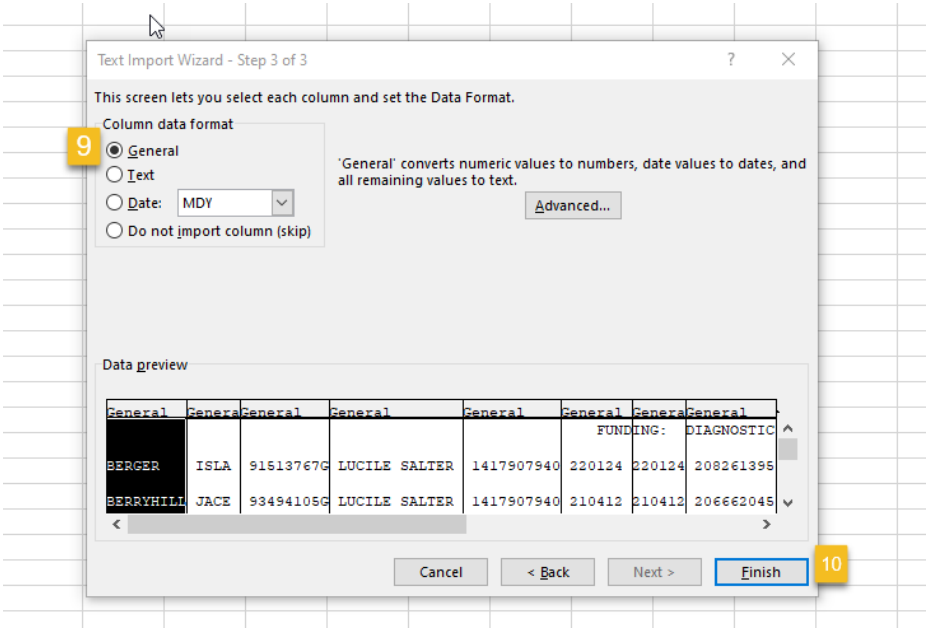
5. Text Import Wizard window will open in excel. Click on “Fixed Width”.
6. Click “Next”.



7. Use the right, left, up and down arrows to view the text and to align the break lines. These break lines will divide the data into columns.
8. Click “Next”.

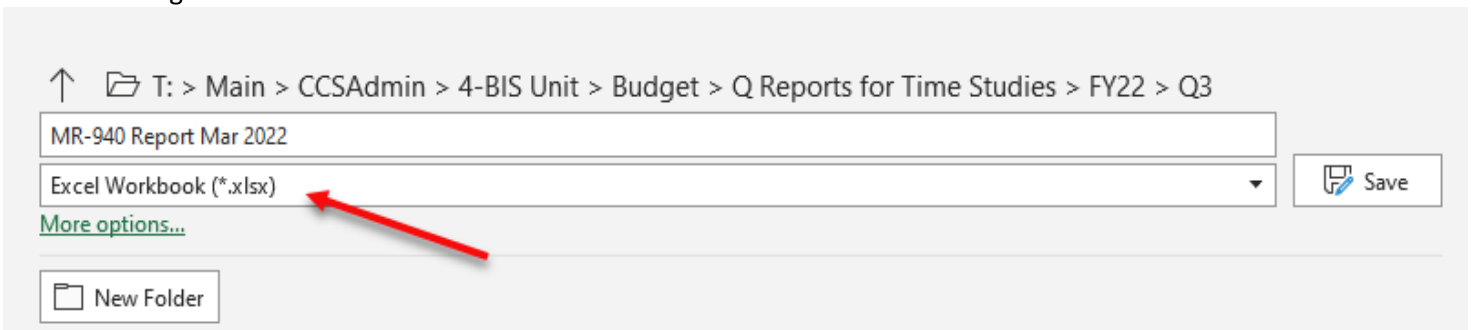


9. Make sure the Column Data Format is “General”.
10. Click “Finish”.



11. Delete the extra rows, page numbers and extra headers.

12. Do not forget to save the file as Excel Workbook.



Use the MR-O-910/MR-O-940 reports to identify, track and correct errors in claims payment according to CCS Information Notice 19-06.

Reviewing MR-O-910 & MR-O-940 Reports

Processes and procedures for reviewing MR-0-910 and MR-0-940 reports vary county by county. Some counties have very specific procedures in place. The guidelines below are general and are not intended to supersede processes that might already be in place in your county. Use this section of the manual along with instructions and forms contained in CCS Information Notice 19-06.

Check for Payments and Credits from Incorrect Fund Sources:

- Use MR-O-940 –Funding Source Cheat Sheet to identify if claims are paid from the correct funding source.
  - Create an Error Log for internal purposes to monitor. Below is a sample Error Log.

MR-O-940 Charge Errors

Name	CCS#	DOS	Amount	940 Run DT	Issue	Date submitted for correction	Date Corrected	Corrected amount	Comments.

  - Identify if correction will be via Erroneous Payment Correction (EPC) or Manual Claims Correction Process.
    - See CCS Information Notice 19-06 to determine if you must wait for an EPC, or if a manual fund source shift will be required.
      - EPC is used for retroactive Medi-Cal coverage
      - EPC is used for Dx payment errors (when client has OTLICP)
      - Manual Claims Correction is needed for errors between counties and between OTLICP funding sources (between 9U and 9R)
- If a credit is reflected, check the Error Report Spreadsheet to see if we are tracking for correction.
  - If successful credit, reflect on an Error Log
  - If there is an apparent Failed EPC (equivalent credit and charge back), record the failed EPC and date on the Error Log
- Ensure correct Anticipated Recovery Percentage – See table on next page.

County Share Recovery Percentage

Beginning 10/1/20 the OTLICP Federal Matching Rate changed from 76.5% to 65%. The below equations are only accurate for dates of service from 10/1/20 onward. For dates of service between 10/1/2019-9/30/20 replace the 17.5% with 11.75% to calculate the county share recovery percentage. For dates of service between 10/1/15 – 9/30/19 replace the 17.5% with 6% to calculate the county share recovery percentage.

Paid Fund Source	**Correct Fund Source**	**County Share Recovery %**	**Explanation (county share math)**
9K Dx	9U: Fed/State/County Tr 65/17.5/17.5 (OTLICP)	32.5%	50% - 17.5% = 32.5%
9K Dx	9R: Fed/State 65/35 (OTLICP)	50%	50% - 0% = 50%
9K Dx	9N: MC	50%	50% - 0% = 50%
9K Tr	9U: Fed/State/County Tr 65/17.5/17.5 (OTLICP)	32.5%	50% - 17.5% = 32.5%
9K Tr	9R: Fed/State 65/35 (OTLICP)	50%	50% - 0% = 50%
9K Tr	MC	50%	50% - 0% = 50%
9U: Fed/State/County Tr (OTLICP)	9R: Fed/State 65/35 (OTLICP)	17.5%	17.5% - 0% = 17.5%

MR-O-940 Corrections of Errors Procedure

Expenditures for CCS only (CCS clients with no Medi-Cal eligibility) and Other Targeted Low-Income Clients Program (OTLICP) clients are reported weekly (MR-O-910) and monthly (MR-O-940) by county, client name, provider and date of service.

Each county is responsible for reviewing their monthly MR-O-940 report for errors. When an error is discovered on the MR-0-940 Reports, it is imperative that requests for corrections are submitted immediately. Corrections to MR-O-940 reports cannot be corrected 18 months past the date of adjudication. The date of adjudication is defined as the date a claim is thoroughly processed through Fiscal Intermediary's claims processing system.

The following correction procedure applies to claims erroneously adjudicated from CCS Treatment Funds that are not captured by the EPC.

The county will take the following steps to have the error corrected:

- County staff must report errors via the Memo to Correct MR-O-940 Report Errors Form
- County staff must prepare the CCS MR-O-940 Correction Transmittal Form. A Correction Transmittal Form is required for each client.
- County staff must forward the completed forms with all supporting documentation to ISCD for review and approval.

Supporting documentation includes but is not limited to:

- Copy of MR-O-940 report
- Memo to Correct MR-O-940 Report of Errors form
- CCS MR-O-940 Correction Transmittal Form
- Copy of any other supporting documentation

ISCD staff reviews and verifies the Memo to Correct MR-O-940 Report of Errors, CCS MR-O-940 Correction Transmittal Form and supporting documentation for each error requesting correction.

If the error correction(s) is verified and approved by ISCD staff, ISCD will take the following steps:

- Forward a copy of the approved Memo to Correct MR-O-940 Report of Errors to the originating county for their records.
- Forward a copy of the CCS MR-O-940 Correction Transmittal, and all supporting documentation to Fiscal Intermediary Cash Control Unit for processing.
- Keep a copy of the CCS MR-O-940 Correction Transmittal, Memo to Correct MR-O-940 Report of Errors and all supporting documentations for your records.
- Approved adjustments will appear on future MR-O-940 reports once they have been processed by Fiscal Intermediary.

If the error correction(s) is not approved by ISCD staff, ISCD will take the following steps:

- Return the original Memo to Correct MR-O-940 Report of Errors, CCS MR-O-940 Correction Transmittal Form and supporting documentation with a denial explanation to the originating county for their records.
- Keep a copy of the MR-O-940 Correction Memo for your records.

Medi-Cal Full Scope, no share of cost corrections

For CCS clients, including OTLICP subscribers, who have become retroactively eligible for Medi-Cal full scope, no share of cost or who have met their Medi-Cal share of cost late in a month, an Erroneous Payment Correction (EPC) will be run in the payment system twice in each fiscal year. The EPC will systematically shift payments to Medi-Cal that were originally

paid CCS-only or OTLICP. The process involves voiding the original payment and reprocessing essentially a new claim using the revised eligibility.

Counties can track the EPC results in two ways:

- The amount voided for the claim will be added back as a credit (negative amount) adjustment to the year-to-date expenditures on the county's online allocation screen in ACS Net, with a concomitant increase in the remaining balance.
- The voided claims will appear on the MR-O-910/940 reports as a credit or negative adjudicated claim line.

Providers will see the results of the EPC on their payment remittance advice as adjustment code 0975. In the case where the error correction for a CCS/Medi-Cal recipient is not captured during the most recent EPC or the correction requires immediate action the above MR-O-940 error correction process may be used.

CCS-only corrections

All other MR-O-940 error corrections (such as wrong county and crossovers between OTLICP Expenditures). The county will take the following steps to have the error(s) corrected:

- County staff must report errors via the Memo to Correct MR-O-940 Report Errors Form and forward the completed form with all supporting documentation to ISCD for review and approval.

Supporting documentation includes but is not limited to:

- Copy of MR-O-940 report
- Copy of CMSNet Program Eligibility screen print (reflecting program eligibility on that date of service in another county)
- Copy of the OTLICP Meds Inquiry Screen
- Copy of any other applicable supporting documentation

ISCD staff reviews and verifies the Memo to Correct MR-O-940 Report of Errors and supporting documentation for each error requesting correction.

If the error correction(s) is verified and approved by ISCD, take the following steps:

- Forward a copy of the approved Memo to Correct MR-O-940 Report of Errors to the originating county for their records.
- Forward a copy of the Correction Transmittal, and all supporting documentation to CMS Fiscal Unit for adjustments.

If the error correction(s) is not approved by ISCD, ISCD will take the following steps:

- Return the original Memo to Correct MR-O-940 Report of Errors and supporting documentation with a denial explanation to the originating county for their records.
- Keep a copy of the MR-O-940 Correction Memo for your records.

If you have any questions regarding these procedures, please contact ISCD.

MR-O-910/MR-O-940 Funding Categories

REPORT NO. MR-O-940 DEPARTMENT OF HEALTH CARE SERVICES PAGE
REPORT DATE CALIFORNIA CHILDRENS SERVICES

REGIONAL OFFICE: SAN FRANCISCO
COUNTY: MONTEREY

---------BENEFICIARY---------- --------PROVIDER--------- DATES OF SERVICE PROC CCS 3RD PARTY ACA 100%
NAME NUMBER NAME NUMBER FROM THRU CCN CODE PAID PAID PAID

FUNDING: DIAGNOSTIC SERVICES (50% County Funds / 50% State Funds)

Correct Payment Source	Incorrect Payment Source
Straight-CCS receiving Diagnostic Services (9K)	Full-Scope Medi-Cal, or OTLICP

FUNDING: SB 75 TREATMENT SVCS, EMERGENCY COUNTY SOC (17.5% County Funds / 17.5% State Funds / 65% Federal Funds)

Correct Payment Source	Incorrect Payment Source
OTLICP (Aid Code 9U)	Straight CCS, Full-Scope Medi-Cal, OTLICP (9R) or Healthy Families (Any)

FUNDING: SB 75 TREATMENT SVCS, EMERGENCY NO COUNTY SOC (35% State Funds / 65% Federal Funds) ***No need to check these!***

Correct Payment Source	Incorrect Payment Source
OTLICP (Aid Code 9R)	Straight CCS, Full-Scope Medi-Cal, OTLICP (9U) or Healthy Families (Any)

FUNDING: SB 75 TREATMENT SVCS, NON-EMERGENCY, COUNTY SOC (50% County Funds / 50% State Funds)

Correct Payment Source	Incorrect Payment Source
OTLICP (Aid Code 9U)	Straight CCS, Full-Scope Medi-Cal, OTLICP (9R) or Healthy Families (Any)

FUNDING: SB 75 TREATMENT SVCS, NON-EMERGENCY, NO COUNTY SOC (35% State Funds / 65% Federal Funds) ***No need to check these!***

Correct Payment Source	Incorrect Payment Source
OTLICP (Aid Code 9R)	Straight CCS, Full-Scope Medi-Cal, OTLICP (9U) or Healthy Families (Any)

FUNDING: SB 75 THERAPY SVCS, NON-EMERGENCY, COUNTY SOC (50% County Funds / 50% State Funds)

Correct Payment Source	Incorrect Payment Source
OTLICP (Aid Code 9U)	Straight CCS, Full-Scope Medi-Cal, OTLICP (9R) or Healthy Families (Any)

FUNDING: SB 75 THERAPY SVCS, NON-EMERGENCY, NO COUNTY SOC ***No need to check these!***

Correct Payment Source	Incorrect Payment Source
OTLICP (Aid Code 9R)	Straight CCS, Full-Scope Medi-Cal, OTLICP (9U) or Healthy Families (Any)

FUNDING: TREATMENT SERVICES (50% County Funds / 50% State Funds)

Correct Payment Source	Incorrect Payment Source
Straight-CCS receiving Treatment Services (9K)	Full-Scope Medi-Cal, or OTLICP

FUNDING: THERAPY SERVICES (50% County Funds / 50% State Funds)

Correct Payment Source	Incorrect Payment Source
MTC Clinic Physician Payments	
Straight-CCS Vendored Therapy Services *(PT or OT services provided via an alternative provider in lieu of MTU)*	Full-Scope Medi-Cal, OTLICP

FUNDING: HF TREATMENT SERVICES (17.5% County Funds / 17.5% State Funds / 65% Federal Funds) ***No need to check these!***

NOTE: Although this line may still show up on the report, this is no longer a valid category.

FUNDING: HF THERAPY SERVICES (17.5% County Funds / 17.5% State Funds / 65% Federal Funds) ***No need to check these!***

NOTE: Although this line may still show up on the report, this is no longer a valid category.

FUNDING: HF 65%/35% SERVICES (35% State Funds / 65% Federal Funds) ***No need to check these!***

NOTE: Although this line may still show up on the report, this is no longer a valid category.

FUNDING: CCS/MEDI-CAL TREATMENT SVCS (17.5% County Funds / 17.5% State Funds / 65% Federal Funds)

Correct Payment Source	Incorrect Payment Source
OTLICP coverage (Aid Code 9U)	Straight CCS, Full-Scope Medi-Cal, OTLICP (9R) or Healthy Families (Any)

FUNDING: CCS/MEDI-CAL THERAPY SVCS (17.5% County Funds / 17.5% State Funds / 65% Federal Funds)

Correct Payment Source	Incorrect Payment Source
OTLICP (Aid Code 9U) Vendored Therapy Services *(PT or OT services provided via an alternative provider in lieu of MTU)*	Straight CCS, Full-Scope Medi-Cal, OTLICP (9R) or Healthy Families (Any)

FUNDING: MEDI-CAL 65%/35% SERVICES (35% State Funds / 65% Federal Funds) ***No need to check these!***

Correct Payment Source	Incorrect Payment Source
OTLICP (Aid Code 9R – over $40K) Treatment Services	Straight CCS, Full-Scope Medi-Cal, OTLICP (9U) or Healthy Families (Any)

Erroneous Payment Correction (EPC) Should Correct Claims in the Following Situations:

- Retroactive Medi-Cal Eligibility (if charged to an incorrect funding source)
- Specific claims payment corrections applied by the fiscal intermediary (aid codes payment fixes – example: historic aid code 82/83 issues)

Manual Claims Corrections are Required for the Following Situations:

- 9U to 9R claims payment correction (claim paid as 9U, but should have been, or has retroactively become, 9R)
- Wrong county charge

Part VII – Resources

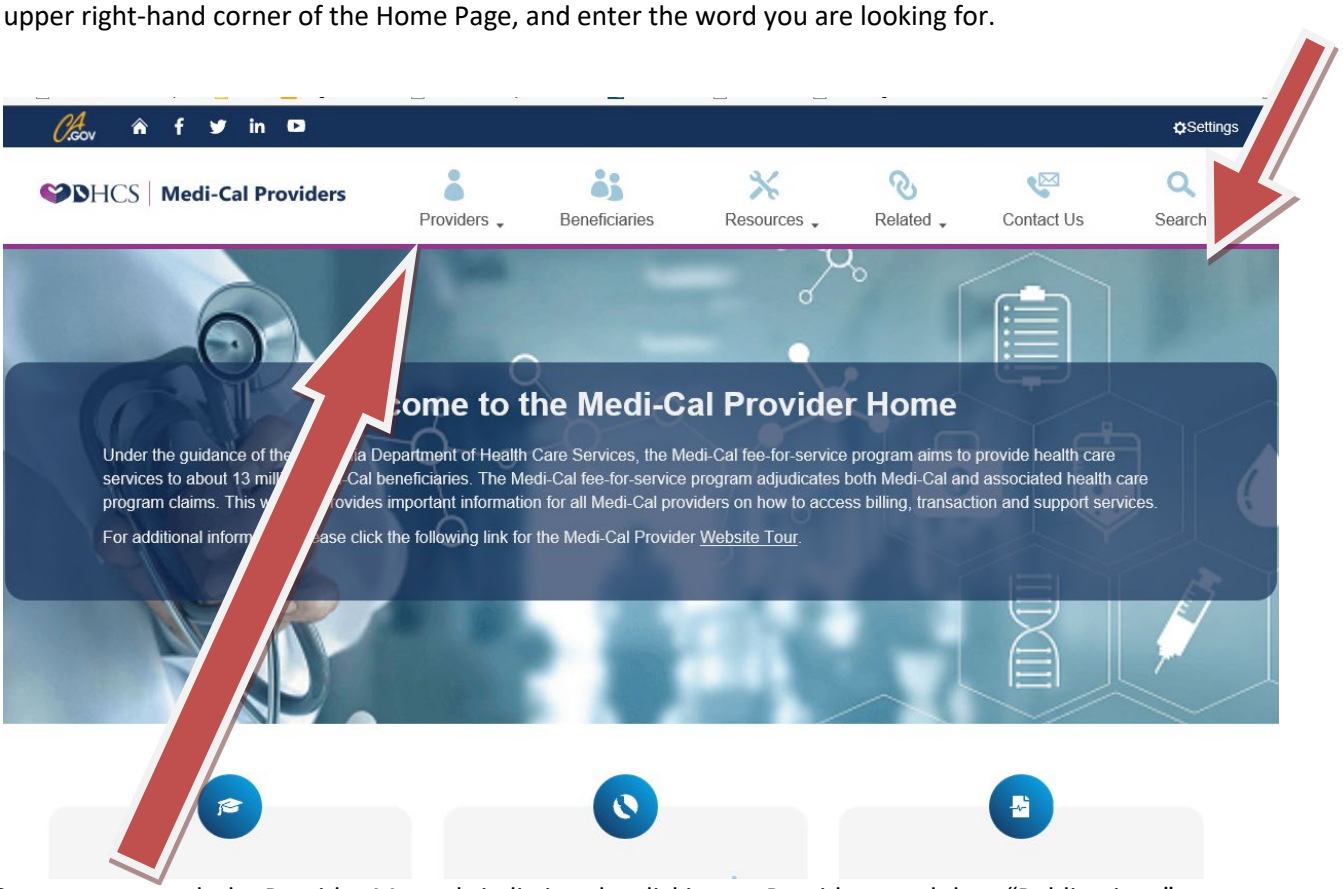
Searching Online for Answers
Provider Claim Return Letter
Glossary of CCS Jargon

Part VII – Resources

Searching Online for Answers	
Numbered Letters and Information Notices	Information Notices and Numbered Letters are used by DHCS to push out updated information. This is the first place to look for information on changes on any business-related process and products. It will be helpful to become familiar with this page and the information contained in it.
This Computes!	This Computes are a valuable source of information to help in determining a product or service use. They are no longer published by DHCS, but an archive can be found in CMSNet. **How to Locate:** From the CMSNet home page, locate Bulletins in the top right corner. Open Bulletins and you will find a link to the Archive. This is an excellent place to begin looking for both creating SARs and finding problem resolutions.
Medi-Cal Outreach and Education Portal	The Medi-Cal learning portal offers online recorded and live trainings about Medi-Cal billing basics, CCS overview, policies, and procedures.
Service Now Portal	The preferred method to contacting the CMS Net Help desk is by submitting a ticket through the Service Now portal for account maintenance, CMSNet service requests, and to upload PTRs. Contact your local County Administrator-Plus to get set up with an account. Login to CMSNet and scroll down to the bottom to determine your local County Systems Administrators.

Medi-Cal Website

The Medi-Cal website is an important place to search for up to date information for all things related to CCS billing. To search for information on a specific keyword or code, click on “Search Medi-Cal” in the upper right-hand corner of the Home Page, and enter the word you are looking for.



Or, you can search the Provider Manuals in listings by clicking on Providers, and then “Publications”.

Tips for using the Medi-Cal search engine:

- Less information works best
- Throughout this toolkit, the best tried and tested search phrases are written in the left side column

Provider Claim Return Letter

Sample Letter to send back to Provider Biller with claims that they send to the County office.

Your County's Letter Head

Date:

Dear Provider:

We are returning the enclosed for the following reason:

___ Services are covered under SAR#_____, enclosed. Please submit directly to The MediCal Fiscal Intermediary (Fiscal Intermediary). Please contact the Medi-Cal help desk at (800) 541-5555 if you have further billing questions. Mail paper claims to Fiscal Intermediary, PO Box 15700, Sacramento, CA 95852-1700.

___SAR# needs to be written in Box 23 of the CMS-1500 claim form
___The physician's name (_____) and NPI on the SAR needs to be entered in Box 17 of the CMS-1500.

___SAR# needs to be written in Box 63 of the UB-04 claim form
___The physician's name (_____) and NPI on the SAR needs to be entered in Box 76 of UB-04.

___ Please submit medical records for the requested date/dates of service so that we can determine if those services relate to the CCS eligible condition.

___Requested services are not related to the child's CCS eligible condition

___This claim is not for a CCS client/CCS case inactive on date of service

___Prior authorization was not obtained

___Child is not a resident of [Your] County. Child resides in _____ County.

___If child has Medi-Cal, resubmit directly to [Insert Managed Care Plan Name Here], along with CCS denial (Enclosed). [Enter address of Managed Care Plan].

If you are getting denials from the Fiscal Intermediary for services that CCS has authorized, please contact the local CCS County office at [phone number].

Commonly Used Jargon in the Billing World

A guide to acronyms for CCS staff assisting providers with denials.

ACSNET – The electronic information system for Medi-Cal fee-for-service claims. Also known as CA-MMIS

BIC – Benefits Identification Card. This is the ID card that the Department of Social Services mails to the client when they are awarded Medi-Cal or CCS. Client presents this card at the provider office or pharmacy as proof of benefits.

CAL POS – California Point of Service. This is the system providers can use to submit electronic claims to Fiscal Intermediary.

CA-MMIS – California Medicaid Management Information System (see ACSNet)

CCN – Claim Control Number. This is an 11 digit reference number associated with each claim. It is printed on the Remittance Advice Details (RAD) or can be acquired in CalPOS. Handy when contacting the Telephone Service Center (TSC) to get more information on a denied claim.

CIF – Claims Inquiry Form. This is used to request an adjustment for either an underpaid or overpaid claim, request a Share of Cost (SOC) reimbursement or request reconsideration of a denied claim. For more information refer to Medi-Cal Publications CIF Completion and CIF Submission and Timeliness Instructions.

CIN—Client Index Number. This is the unique 9-digit Medi-Cal ID number given to each recipient.
CMC—Computer Media Claims. Claims that are submitted electronically.

CMS-1500 – Commonly used claim form for submitting claims to Fiscal Intermediary. The other is the UB-04, or the Pharmacy 30-1.

COS – Category of Service. If a provider is not eligible for the appropriate category of service, a claim may deny for this reason.

CPT-4 – Physicians' Current Procedural Terminology. Five-digit code entered on claim form to identify the service being billed. CPTs are a Level I HCPCS code, and are numeric.

DHCS – Department of Health Care Services.

DRG – Diagnosis Related Groups. A system of classifying any inpatient stay into groups for the purposes of payment. Payment is based on acuity and not length of stay.

DME – Durable Medical Equipment. Below are the common modifiers used when claiming for DME. The claim will deny if the corresponding SAR does not have the same modifiers as the claim.

- RR – rental equipment
- NU – New purchased equipment
- RP – equipment repair
- RB – labor

EAC – Estimated Acquisition Cost. EAC is equal to the lowest of the following:

Average Wholesale Price (AWP) minus 17 percent
Maximum Allowable Ingredient Cost (MAIC)
Federal Upper Limit (FUL)

EPC – Erroneous Payment Corrections. These are adjustments that are made to payments that were processed from an incorrect funding source (for example a claim that was paid out of county funds when it should have been paid out of federal funds). The system is set to automatically search for certain common errors during regularly scheduled runs. The CCS program can submit a request for a specific correction.

EPSDT-SS –Early and Periodic Screening, Diagnostic, and Treatment Supplemental Services. Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

FI – Fiscal Intermediary. The entity contracted by the Department of Health Care Services to process and pay Medi-Cal fee-for-service claims. The current FI is Gainwell Technologies (formerly DXC, formerly ACS Xerox, Formerly HP, formerly EDS). 1-800-541-5555.

FUL – Federal Upper Limit. The maximum cost limits for certain drugs.

HCPCS – Health Care Procedure Coding System. Pronounced "hick picks." A standard set of procedure codes used in medical billing. Level I codes consist of CPT codes and are numeric. Level II codes are alphanumeric and include non-physician services and supplies.

HRIF – High Risk Infant Follow UP

ISCD – Integrated Systems of Care Division. This is the division at the Department of Health Care Services that has oversight of the CCS program.

MAC – Maximum Acquisition Cost. The manufacturer, relabeler or distributor has guaranteed that Medi-Cal providers, upon request, will be able to purchase the contracted item at no greater than the maximum acquisition costs for dispensing to eligible Medi-Cal recipients.

MOPI—MEDS Online POS Inquiry. This screen contains the same client insurance information the providers see when running a client through the Medi-Cal online Eligibility Response System.

MR-O-940 – a monthly report detailing diagnostic and treatment expenditures for the CCS-only (CCS clients with no Medi-Cal eligibility) and OTLICP clients. (See MEDS User Guide for details).

NBHS – New Born Hearing Screening

NDC – National Drug Code. A unique 10-digit, 3-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. Used in billing for medications.

NOA – Notice of Action. This is a correspondence that is sent to the client and provider when a service request is denied.

NPI – National Provider Identifier. A unique 10-digit identification number issued to health care providers by the Centers for Medicare and Medicaid Services.

OHC – Other Health Coverage. A provider must bill any other health coverage first before billing Medi-Cal or CCS.

PMF – Provider Master File. A list maintained by Medi-Cal of all active Medi-Cal enrolled providers. A provider can be CCS paneled but be non-PMF. SARs are issued to the clinic or physician group that they are affiliated with.

PTR—Patient Therapy Record. A form generated in CMS Net used to document Physical Therapy and Occupational Therapy billable activities at the MTU. Used for billing direct treatment services.

RAD—Remittance Advice Details. A RAD lists providers' claims for a particular payment period. It is used by providers to reconcile their records with claims that have been paid, denied or suspended.

RAF – Referral Authorization Form. The form that a provider sends to Medi-Cal Managed Care when requesting services for a non-CCS condition.

RTD – Resubmission Turnaround Document. This form is send to providers when a submitted claim has questionable or missing information. It eliminates the need for providers to resubmit the entire claim form to correct a limited number of errors.

SAR – Service Authorization Request. The form submitted by a provider to the CCS County office when requesting authorization for services. Once approved, an authorization is generated. The biller must enter the SAR number in field 23 of the CMS-1500 claim form or field 63 of the UB-04 claim form. The SAR # is an 11-digit number beginning with 97. If it is an EPSDT SAR it will begin with 91. If it is a brand name over-ride, the last 2 digits of the SAR will be 01.

SCG – Service Code Group. Groups of service codes that authorize a provider to render any of the services included in the group.

SOC – Share of Cost. Medi-Cal recipients with a Share of Cost must pay a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. If a child with a SOC has CCS, the local County CCS may be able to pay (obligate) the SOC if the service is related to the CCS eligible condition and if obligating the SOC is significantly less than paying for services out of straight-CCS funds. County CCS cannot use State CCS Funds or County matching funds to pay SOC.

TAR – Treatment Authorization Request. This is Medi-Cal's version of a CCS SAR. Only certain procedures and services are subject to authorization with a TAR.

TAR 1 – No TAR required

TAR 2 – non-benefit status. For CCS services deemed medically necessary, see This Computes 421 for work around.

TAR 3 – payable without an NDC on SAR if drug is in a compound.

TCN – TAR Control Number. This is the unique number that identifies a TAR.

TSC – Telephone Service Center for Fiscal Intermediary, The phone number is **1-800-541-5555**. This is also the number to call to request a call from a Regional Representative for one-on-one training and support.

UB-04 – Commonly used claim form for a hospital submitting claims to Fiscal Intermediary. The other is the CMS- 1500 or the Pharmacy 30-1.