Children's Regional Integrated

Service System

CCS Claims Training Toolkit

A Desk Guide for CCS Staff

Developed by a subcommittee of the CRISS Claims Work Group. Subcommittee 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

8/24/2017

Note: This Toolkit is geared towards CCS counties that are carved-out of Medi-Cal. If you are a carved-in County or a Whole Child Model County, the claims process will be different for children enrolled in a COHS.

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.

Claims Training Toolkit

Press the Ctrl key and click on a link to go directly to each section.
Press Ctrl+F to search the manual by keyword.

Part I—Background Information
The General CCS Claims Process

Part II—Authorizing Services
Tips for Preventing Denials

Part III—Claim Denial Troubleshooting
Tips for Helping Providers Resolve Denied Claims

Part IV—Client Gets a Bill
Tips for Helping the CCS Client if Client is Billed in Error

Part V—Other Issues
PTR Tips

Part VI—MR-0-940s

Part VII—Resources
Searching on-line for answers
MEDS Guide for CCS users
ACS Net Guide for CCS users
Provider Claim Return Letter
Glossary of CCS Jargon

Numbered Index

Part I – Background Information – The General CCS Claims Process **4**
CCS and Other Coverage 4
Co-pays and Deductibles 7
EPSDT 8
MEDS for Coverage Information 9
Part II – Authorizing Services – Tips for Preventing Denials **10**
Know Your SARs and Service Code Groups 11
Inpatient and Outpatient SARs 12
Pharmacy SARs 13
Restricted Drugs 14
Correct Configuration for Units and Quantity 14
Understanding TARs and SARs 15
DME SARs 16
Miscellaneous SAR Information 16
Common SAR Mistakes 18
Paneling Guidelines 19
Part III – Claim Denial Troubleshooting – Tips For Helping Providers Resolve Denied Claims **21**
How to Use the SAR to Get Paid 22
Common Problems and Solutions 22
Pharmacy Says "Help! This Authorization Won't Work!" 24
Common Problems and Solutions by RAD Code 25
Issues Related to Coverage – Check MEDS 27
Scenarios In Which ACSNet is a Resource 28
Part IV – Client Gets a Bill – Tips for Helping the CCS Client if Client is Billed in Error **29**
Client Gets a Bill – Procedure example from Humboldt County CCS 30
California Welfare and Institution Code Section 14019.4 32
Sample Letter for Parent to Send to Biller 33
Part V – Other Issues – PTR Tips **34**
Sample PTR 35
Part VI – MR-O-940 Reports **36**
Instructions for Downloading MR-O-940 Reports 37
Reviewing the MR-O-940 Reports 46
Correcting Errors on MR-O-940 reports 47
Sample MR-O-940 With Funding Sources Listed 50
Part VII - Resources **52**
Searching On-Line for Answers 53
Provider Claim Return Letter 54
Commonly Used Jargon in the CCS Billing World 55

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
Medi-Cal Managed Care—6 models in CA: **COHS**—County Organized Health Systems. **GMC** – Geographic Managed Care **Two-Plan Model** **Regional Model** **Imperial** **San Benito**	If CCS is Carved-Out of the Managed Care Plan: • Provider must submit CCS claims to Conduent with a SAR. • Conduent pays CCS claims for child with Medi-Cal Managed Care. ➢ Provider must bill as fee-for-service, NOT the Managed Care Plan. ➢ Important – many providers do not know this and try to bill the Managed Care Plan • Managed Care Plan will deny a claim if it is CCS eligible. • Managed Care Plan pays claims for services not related to the child's CCS eligible condition If CCS is Carved-In to the Managed Care Plan, provider submits all claims to the Managed Care Plan, even for CCS services (Carved-In counties are Marin, Napa, Solana, Yolo, San Mateo, and Santa Barbara) Phone Tip for Carved-Out counties: When a provider calls to say a claim was denied, you might ask first "Did you submit the claim to [insert the name of your Medi-Cal Managed Care] or to Conduent?"
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. Full text of SB 586.
PPO or OHC	**If a child has a PPO, the PPO is the primary payee. 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. The PPO payment is usually higher than Medi-Cal allowable rate.
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).

Return to Index

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 CCS is primary for DME
Medicare Part A & B HCPI-NUM 990 (on MEDS QM screen)	Medicare is primary payer. Medicare must be billed before billing Medi-Cal.

Return to Index

Co-pays and Deductibles	
Primary Insurance Payment	If the amount paid by the primary insurer **>** 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 **<** 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. Parent/Client/CCS need to make sure their providers are in-network. CCS should not issue an auth to a provider that is out-of-network for the private insurance. If insurance denies a claim due to it being out-of-network, CCS will not pay/SAR will not work. Plus, 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 co-pay '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 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 case until the SOC is spent down each month. Once the SOC is met the services can be billed as full-scope M/C.
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.

Return to Index

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 – biller must have EOBs showing timely billing attempts and submit to Over 1 Year Unit • If client has full scope M/C, submit to Xerox. EOB not necessary.

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.	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.
Some common CCS EPSDT-SS Benefits	Hearing Aids, This Computes! 363 Speech and Language Therapy, Numbered Letter 15-0605 Vitamins and Supplements, This Computes! 421, This Computes! 413 Private Duty Nursing, This Computes! 322 Non-covered diabetic supplies

Return to Index

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) Exception: 6V/6E = Regional Center DDS waiver (no cash benefit)
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.

Return to Index

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.
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 "cal child ser" in the search field.	• SCG 01 – Physician (covers office visits, most medications, 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 (can be used by the pharmacy for most meds). • 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
Drug codes not in SCG Table	All FDA approved drugs are contained in the Service Code Groupings (excluding drugs that require specific authorization by CCS). DMEs and Medical Supplies are not includes in SCGs. To find their status, go to the Medi-Cal Provider Manual (on-line). Or enter the Code or NDC into ACSNet for a current TAR status.

Return to Index

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 • As of 1/2/15 CCS covers the entire stay at Designated Public Hospitals even if child was only CCS medically eligible for part of the stay. Numbered Letter 04- 0715.
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 an 02 SAR. • Hospital 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
Out-Patient Facility SAR	• Out-Patient facility can bill with physician's SAR, but must complete the claim correctly or it will deny. • Physician must share w/facility • Physician named on the SAR is the 'referring provider' for Out-Patient billing • 01 should include any anticipated procedure codes not already included in 01. • ER visits not resulting in an I/P – 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, NL 07-1215
Non-PMF provider	Issue the auth to the facility when using a Non-PMF provider. Cannot issue the auth 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)

Return to Index

Pharmacy SARs	
Most Medications	Most Medications are covered under an 01, 02, or 08 SAR. Medical Supplies, Brand name drugs, restricted medications and compound drugs require a specific SAR (more details on specific requirements below).
How a pharmacy uses a SAR: Electronic vs. manual claims	For Most medications and supplies, the pharmacy can run the claim with the SAR # electronically in CalPOS and get an instant response on payment or rejection. Some requests require the pharmacy to submit a manual claim for payment. Manual claims must be submitted when: 1) "0" pricing in ACS Net, 2) using a Z5999 SAR.

Z5999 Workaround	Use for: End-dated, No pricing on file, Non-Benefit (medical foods, OTC etc.):
	• All = TAR 2
	• Require manual billing
	• Submit on CMS-1500 with:
	  ○ Copy of SAR
	  ○ Invoice or manufacturer's catalog page showing cost of product
	• ONLY one Z5999 per SAR
	• Only one Z5999 per billing date
	Requires specific Special Instructions. See: This Computes! 421.

T5999 Workaround	Use for Non-FDA approved Medical Supplies • Albustix • Reagent Strips • Silver Nitrate sticks/applicators • Add the NDC to the Special Instructions • Requires manual billing This Computes! 366, Info Notice 14-09
Glucose Monitors	• Requires HCPCS • Use E0607 on SAR – In Special Instructions on the SAR, enter: E0607 APPROVED FOR [enter NDC] [product name]. CLAIM MUST BE SUBMITTED MANUALLY, AND BILLED WITH MODIFIER NU. CLAIM MUST INCLUDE THE APPROPRIATE HCPCS CODE (E0607) AND A STATEMENT THAT THE EQUIPMENT IS PATIENT-OWNED IN THE "ADDITIONAL CLAIM INFORMATION" FIELD, (BOX 19). Special Feature—see Medi-Cal manual to use E2100/E2101
Sterile Needle	• Use procedure code A4215. Provider must bill manually with invoices.
Units and Quantity	• See This Computes! 329 • See the examples on the next page
FUL, Brand Name and Price Over-ride SARs	• Use for Brand Name over-ride and when the pharmacy's acquisition cost is less than the Federal Upper Limit (FUL). See NL 16-07, This Computes #102 and This Computes #275
Have a question that does not seem to be addressed anywhere?	Contact the CMS Branch Pharmacy Consultant: • Edan Lum, 415-557-1058 or edan.lum@dhcs.ca.gov

Return to Index

Restricted Drugs: Require a Separate SAR issued to the Pharmacy. For the most up-to-date listing go to https://www.medi-cal.ca.gov/ and enter cal child sar into the search field.	
All Brand Name Drugs	Brand Name drug SAR # must end in "1." Correct box must be checked when generating the SAR. See This Computes!102 for more information
AbobotulinumtoxinA	Infant Formulas
AHF, Human/VWF, Human	Intrathecal Baclofen
Anti-inhibitors	Leuprolide Acetate
Antithrombin III	Minerals/Protein-Replacement-Supplements
Botulinum Toxin Type A	Nutritional therapy for Phenylketonuria PKU
Botulinum Toxin Type B	Nutritional Therapy
Dietary Supplements	Special Formulations
Factor VIIa (Recombinant)	Palivizumab
Factor VIII (Human)	Sapropterin Dihydrochloride
Factor VII (Recombinant)	Sildenafil
Factor IX (Heat Treated	Somatrem
Factor IX (Non-recombinant)	Somatropin
Factor IX (Recombinant)	Tadalafil
Food Oils	Vardenafil
Immune Serum Globlin (IV)	Von Willebrand Factors
Immune Serum Globlin Caprylate IV	
Immune Serum Globlin Maltose IV	

Correct Configuration for Units and Quantity Example - See This Computes! 329						
Service Code	Type	Modifier	Service Description	Units	Quantity	Amount
00193654621			Microlet Lancets	5	200.0	
00193288050			Ketostix Reagent Strips	5	50.0	
A4215	1		Sterile Needle	1200		
E0135		NU	Walker	1		

- In the above example:
  - Units are the number of months and Quantity is the number of items dispensed per month
  - HCPCS codes A4215 and E0135 are entered by the number of items dispensed in total for the life of the SAR
  - HCPCS E0135 requires a modifier

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.**
  - **The second step would be to research the code or NDC in ACSNet.**
    - **Verify Units Used**
    - **TAR Status**

Return to Index

Understanding TARs and SARs for Pharmacy Requests	
A TAR is the Medi-Cal authorization request for all adults and children who are not open to CCS. A SAR is the equivalent authorization for CCS cases. Use the Formulary Inquiry in ACSNet to look up TAR status of drugs that you are not sure how to authorize.	
TAR 1 or 0 • $0.00 pricing on file • Or, pricing is End Dated	Issue a code specific SAR. Provider must bill with invoices and/or catalogue pages. Note: whenever there is no pricing on file, the claim will deny. Providers must supply the pricing in the form of current manufacture's catalogue pages and or invoices showing their purchase price.
TAR 1 or 0 • Pricing is on file • And, pricing is End Dated	• For DOS prior to End Date, use a 01 or 02 SAR. • For DOS after End Date, NDC Specific SAR required and provider must bill with invoices or manufacture's catalogue page copies.
TAR 1 or 0 • Pricing on file • Pricing is not End Dated	• Use an 01 or 02 SAR
TAR 2 • Requires Z5999 Override SAR	Regardless of pricing, these codes require a Z5999 override. They are pharmacy products. The pharmacy will have to bill manually. See This Computes! 421 for specifics.
TAR 3	Payable without a NDC on the SAR if the drug is a compound
Not on Formulary	There is no workaround. NDC codes not listed not on the Formulary are not Medi-Cal benefits and will not pay. **Tip:** If NDC does not come up, try adding 1 or more zeros to either the front or back of the NDC code. The search field requires 11 digits. Pharmacies will often request NDCs with only 9 digits.
Pricing not on file in the Formulary	When the pricing has been 'pulled' by Medi-Cal, the reimbursement rate for the code is 'under review'. The provider must bill with invoices or current catalogue page copies to establish the reimbursement rate.
NDCs Not In CMSNet	See This Computes! 275 for help.
Rebates	Pharmacy cannot collect rebates.

Return to Index

DME 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.

Miscellaneous SAR Information	
By Report	This designation in Medi-Cal means the code requires its own SAR. 1. Go to Medi-Cal website, then Provider Manual 2. Enter the HCPCS in the search window 3. Select the most likely result and check if By Report, or By Report Not Specified
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.

Return to Index

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.

Return to Index

Common SAR Mistakes
• Brand Name SAR box is not checked. Brand name drug SARs must end in '1'. See This Computes! 102 • SAR doesn't specify a brand name drugs. • Modifiers are missing from DME SARs • Unit / Quantity is missing or incorrect. See This Computes! 329 • Synagis amounts are wrong. • 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. •

Return to Index

Paneling Guidelines	
Web site link to Paneling Desk	Link to application for paneling. Process takes about 2 weeks from date of submission by provider: http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx
Paneling Desk Address & Phone Number	Children's Medical Services Branch Provider Relations Unit MS 8100 PO Box 997413 Sacramento, CA 95899-7413 916-322-8702
State Provider Enrollment	Provider not yet registered with M/C – Provider must call this number and leave a message – no live bodies at this number. They will call back in up to 48 hours. They will tell the provider which forms must be submitted. Process takes about 6 months.
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, Orthotists, 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 doc paneled. • Paneling date is issued by State for date of application • Doc saw child before paneling date • **CCS must send letter to paneling desk requesting Retro Paneling.**
Temp Paneling	• Lasts 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

Return to Index

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 denials for all resulting billing by ancillary staff and services (labs, radiology, etc.)

Return to Index

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. • In billing, the physician on the SAR **must** be on the claim. • 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 of the physician on the SAR **must** be on the billing.
Pharmacy (30-1)	Used if manually billing with NDC. This is usually used for specialized billing such as for dialysis clinics or infusions treatments.
CALPOS	Check CALPOS in ACSNET to look for errors (The ACSNet guide has instructions to see CALPOS Pharmacy Claim Rejection History)

Common Denials and Solutions		
Denial Type	**Possible Reason**	**Possible Solution**
CCS eligible Bill to other processor Bill GMC or OHC	Biller submitted claim to the managed care instead of to Conduent	Ask biller if they submitted the claim to [*enter county managed care name*] or to Conduent? They need to submit the bill to Conduent. Manual Claims get sent to Conduent PO Box 15700 Sacramento, 95852-1700. Make sure they have the SAR # and tell them to enter the SAR # in Box 23 of the CMS-1500 form or Box 63 of the UB- 04.

Return to Index

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
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 an 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)
Pharmacy provider states "We always get paid with that SAR"	They may be trying to use an 01 or 02 for a medication that requires its own SAR or for a medical supply. Medical supplies are not covered by an 01 or 02.	Pharmacy may need their own SAR with the drug or supply NDC #. SAR may be expired SAR may need additional units/quantity
Pharmacy Error Code 21	HCPCS and NDC have not been linked. In the pharmacies system.	Pharmacy needs to call their headquarters and have the linkage made. The big pharmacies (CVS, Walgreens, Rite Aid, Safeway) have built internal formularies to allow for manual billing. Formulary changes requiring manual billing for formally payable products may need to be uploaded to the pharmacies corporate formulary. CCS should contact the corporate office with the new information.

Return to Index

Pharmacy says, "Help! This authorization won't work!"	
CVS Compounds	Use Submission Clarification code 8 to pay for 'active ingredient only'
CVS Manual Billing	Instruct pharmacy to bill DME using Condor code 231.
CVS No Resolution found	Contact CVS Corporate. Give Store number, phone number and contact name: 866-528-7272 option 5 EX 14 This office will contact the store and assist with resolving the billing issue.
CVS Error 21	The HCPCS or NDC has not been linked in the CVS manual billing system. Contact the corporate office and request the code be added.
Rite Aid Compounds	Use Submission Clarification code 8 to pay for Active ingredient only
Rite Aid Manual Billing	Instruct pharmacy to bill DME to 'Off Line Card' If the NDC does not pay, contact the corporate office. The NDC may need to be added to the 'Off line' formulary. Most of the regularly billed DME and Endocrine meds/supplies are there. But occasionally we find one that is not yet on it.
Rite Aid No Resolution Found	Rite Aid prefers an email: First Contact Michelle Rizzi – mrizzi@riteaid.com Second Contact Ruthann Savion – rsavino@riteaid.com
Safeway	Advise the pharmacy to bill manual claims through the Safeway Omnisis system. Advise they call 3rd Party Help. If both steps fail, contact Steven Holsinger at 925-467-2806 or Stephen.holsinger@albertsons.com
Walgreens	Contact the regional District Manager. Contact local pharmacy for information. Sacramento Region DM: Jason.e.flora@walgreens.com Palo Alto Specialty Pharmacy technician Jane Bercerra is knowledgeable about CCS billing and will assist other stores: jane.becerra@walgreens.com
Walmart	Have Walmart contact their 3rd Party Help Desk at 479-277-7710. They will help the pharmacy staff complete the SAR and/or claim.
Hard Copy Billing (aka Manual Billing)	If billing with NDC – bill with CMS-1500 or Pharmacy (30-1) form If billing with HCPCS bill with CMS-1500

Return to Index

Override Codes	Require override Submission Clarification Code: Try billing with: • 7-medically Necessary (indicates Code 1 Restrictions have been me • 8- Process Compound for approved ingredient only • 99- Other (also indicates Code 1 Restrictions are met and process compounds for active ingredient only Each pharmacy has proprietary software which interfaces with Medi-Cal.

Common Denials and Solutions by RAD Code		
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).
009	Compound Denial	Use 'Y' in Process for Approved Ingredients.
10	Previously Paid	If denial is within 12 week window, find it in ACSNet and give the provider the Warrant # and Date of payment
016	Pharmacy says denial is for 'item not covered'	Check CAL POS to determine if M/C has removed the pricing (See ACSNet Procedures – Formulary Inquiry) If pricing has been removed and the item is still on the Formulary, CCS must generate a Z5999 override SAR and the pharmacy must bill manually.
018	Pharmacy says denial is 'product not covered'	CAL POS shows pharmacy has not added SAR # to billing. (ACSNet Manual—Claim Rejection in Real Time)
036	RTD not submitted	Advise provider rebill. If possible, find RTD to determine denial reason of original claim
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.

Return to Index

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 re: what COS is.
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.
0142	Valid DUR (Drug Use Review) response required (pharmacy is trying to fill the medication too early.	If you confirm with the pharmacy that they are not trying to fill the medication too early, tell the pharmacy to contact the Help Desk (800-541-5555). The help-desk can over-ride the code. The help-desk will check when the last prescription was filled and by whom.
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 pharmacy to ask to speak to a supervisor, or to have their regional rep contact them. This is a common RAD code with Z5999 claims.

Return to Index

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.	View Insurance - MOPI Shift F12 M Enter • Review MOPI when claim is denied for OHC ➢ If PPO: Bill OHC First ➢ If HMO: Close case
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** (if the provider's proprietary software requires entry of issue date – not all do) In MEDS: QM Shift F9 SSN or MEDS ID Give the provider the current issue date.
No Eligibility	Adopted	Has 04 eligibility code; Check for incorrect CINs (provider could be billing with original CIN). Make sure the CIN on the SAR is the correct CIN. An adopted child's CIN is never merged to the new CIN for confidentiality purposes. Use the new 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 a CMC enter statement in the ASCX12N837 Note Segment: Newborn Infant using mother's ID. This information should also be added to Special Instructions in the SAR.

Return to Index

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	Check that provider is using CIN on the SAR. Use CalPOS (ACSNet) Check that the provider has 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	Check if ACSNet is showing the approved units have been used
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.
Item not covered	Item must be billed manually.	Check CALPOS for pulled pricing. Item must be billed manually.
Product not covered	• Pharmacy has not added SAR# to billing. • Pharmacy is not using NDC on SAR	Check CALPOS to see if SAR was used or if the correct NDC code is being used.
Requires Prior Auth	Incorrect SAR # or NDC #	Check CALPOS to see if: • Correct SAR was used • NDC used matched the NDC on the SAR (common error for test
Exceeds Limit	Units on SAR have all been used	Check Rx in ACS Net for: • Number of fills remaining • Over units for the month
Why is our payment amount so low?	Vendor did not request the Medi-Cal contracted rate from the supplier. Vendor didn't bill for the maximum allowable rate. Drug is covered under the FUL process	Check the MAC in ACS Net Formulary, and make sure the vendor did pay the supplier more than this amount. Check the EAC in ACS Net Formulary. Make sure vendor also added in the 23% mark-up dispensing fee. See example below. (Reimbursement for contracted diabetic lancets and test strips is the Maximum allowable Product Cost plus a fixed dispensing fee of $7.25) Generate a FUL SAR (Information Notice 16-07)

Return to Index

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: 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 ***Conduent, 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 Conduent 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 Conduent
    - 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

Return to Index

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.

Return to Index

Sample Letter

(Your name) _____
(Your address) _____
(Your City, State, and Zip Code) _____
(Your phone number) _____
(Today's date) _____

TO: (Name and address of the provider or collection agency from your bill)
_____
_____
_____

RE: (Name and address of the person who got the services) _____
(The account number from the bill) _____
(Date the patient got the 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 got the services)_____, issued on (The date of the card)_____. The date of birth is (Date of birth of the person who got 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 (Conduent).

You may submit a claim to Conduent
Conduent 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) _____

Return to Index

Part V – Other Issues

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:																																	

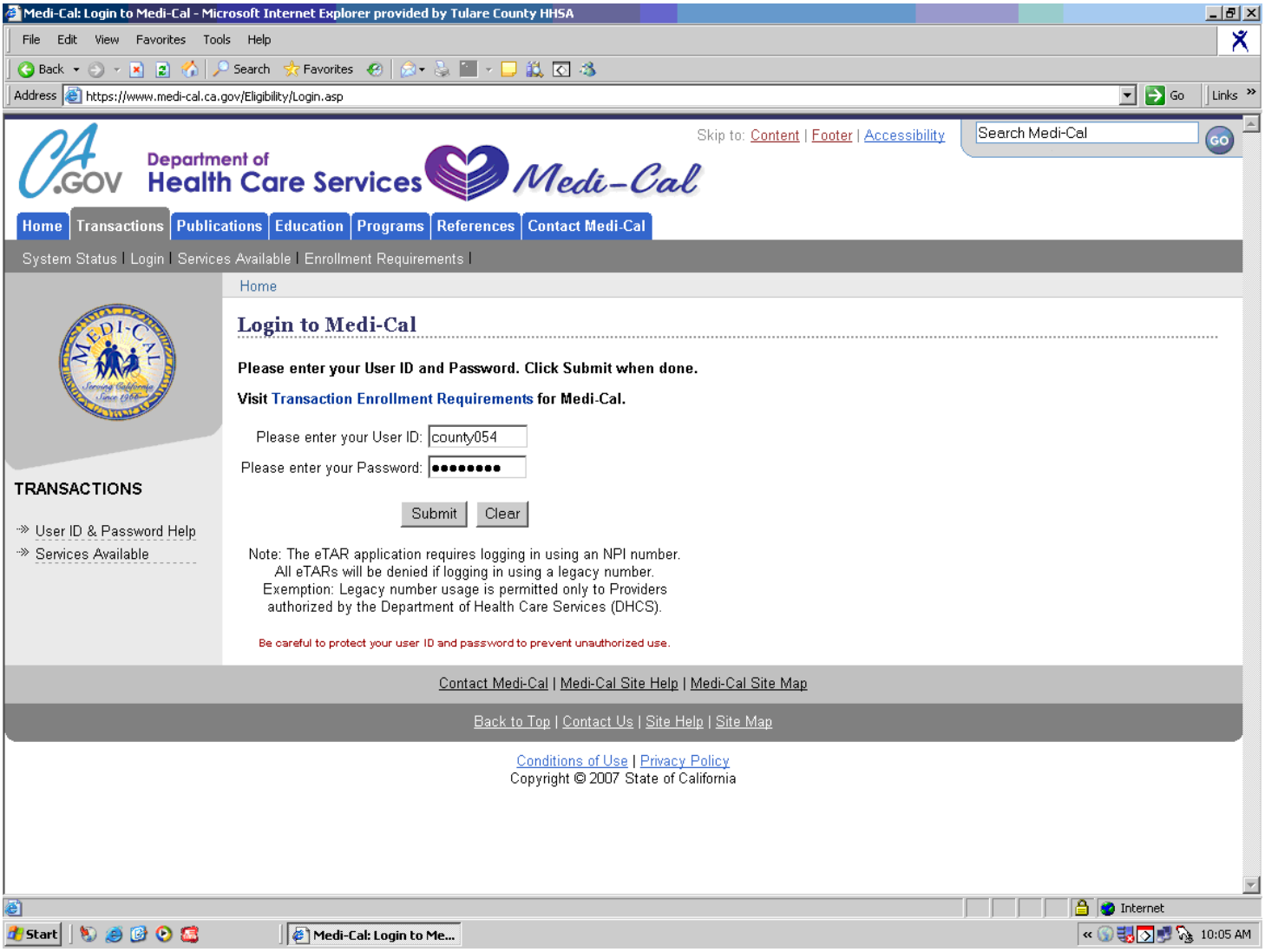
Signature(s)			Date
☐ Physical Therapy ☐ Occupational Therapy	Treatment diagnosis 373.02 - SQUAMOUS BLEPHARITIS		Primary diagnosis 373.01 - ULCERATIVE BLEPHARITIS
Patient Name TEST,CASE		Date of birth 08/01/2008	CIN 32563932A5
CCS number 3279884			
Year 2010	Quarter 1	Medical direction KAISER	County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

Return to Index

Part VI – MR-O-940s

1. **Instructions for Downloading and formatting the report.**
2. **Procedure for Reviewing**
3. **Procedure for Correcting Errors**
4. **Funding Source Cheat Sheet**

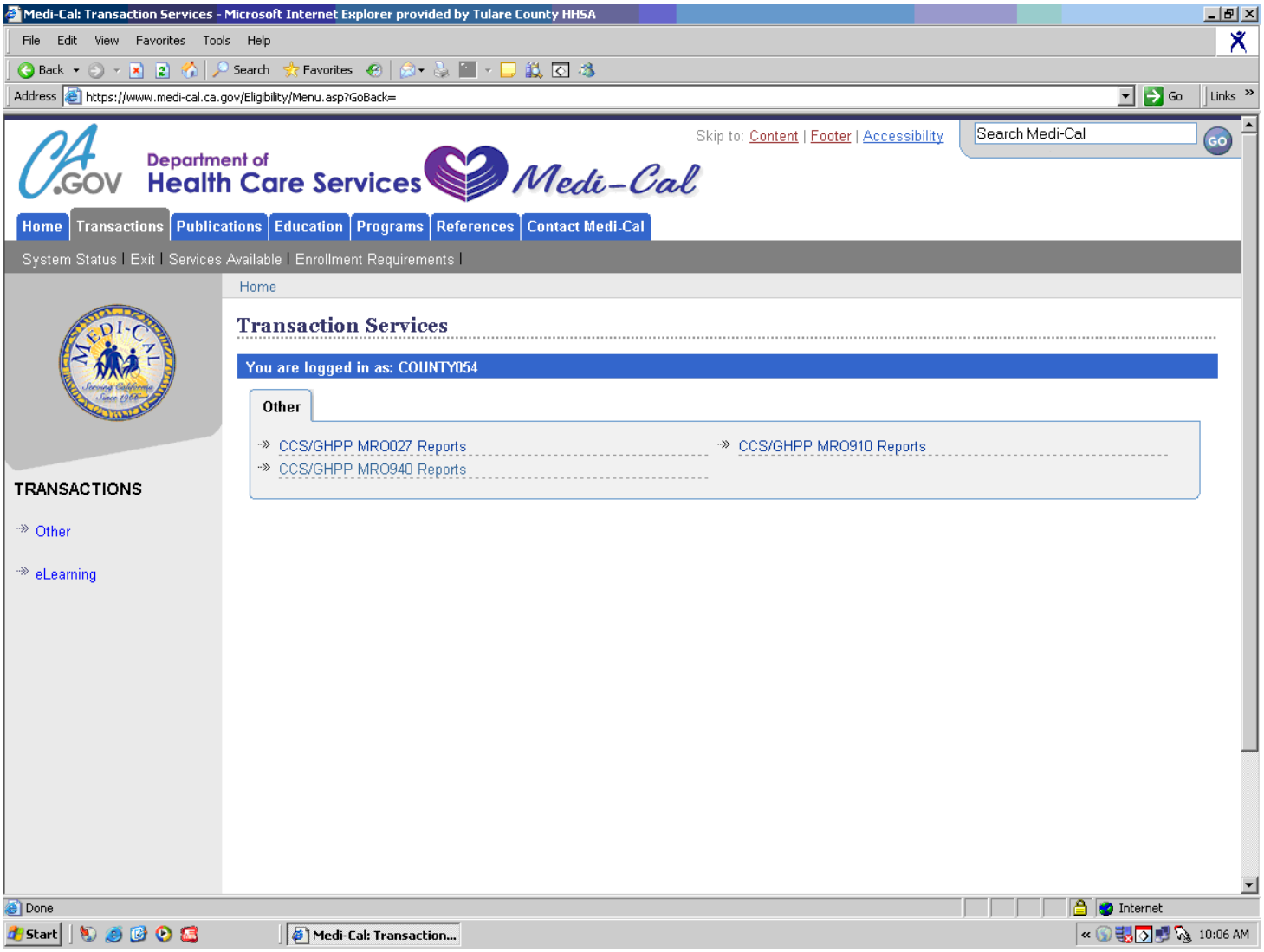
CCS Electronic MR-O-910 / MR-O-940 Reports
Instructions for Downloading



Login to the Medi-Cal website at: https://www.medi-cal.ca.gov/Eligibility/Login.asp

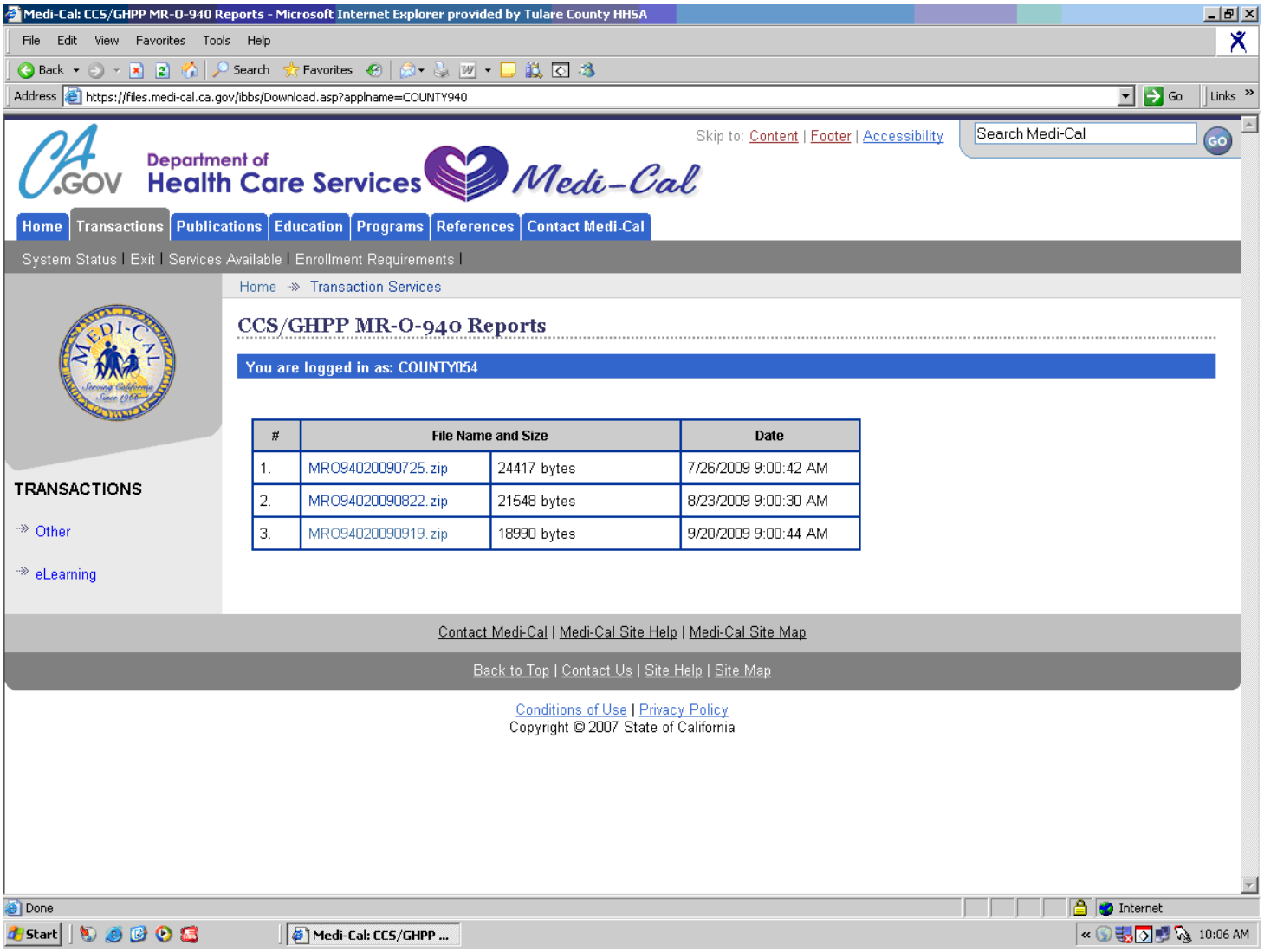
State contact information for assistance with login/password:

Lynn Lee
Information Systems Analyst
DHCS/FICOD/FI-ITMB (MS4712)
Desk: (916) 464-2165
Cell: (916) 842-7838
lynn.lee@dhcs.ca.gov



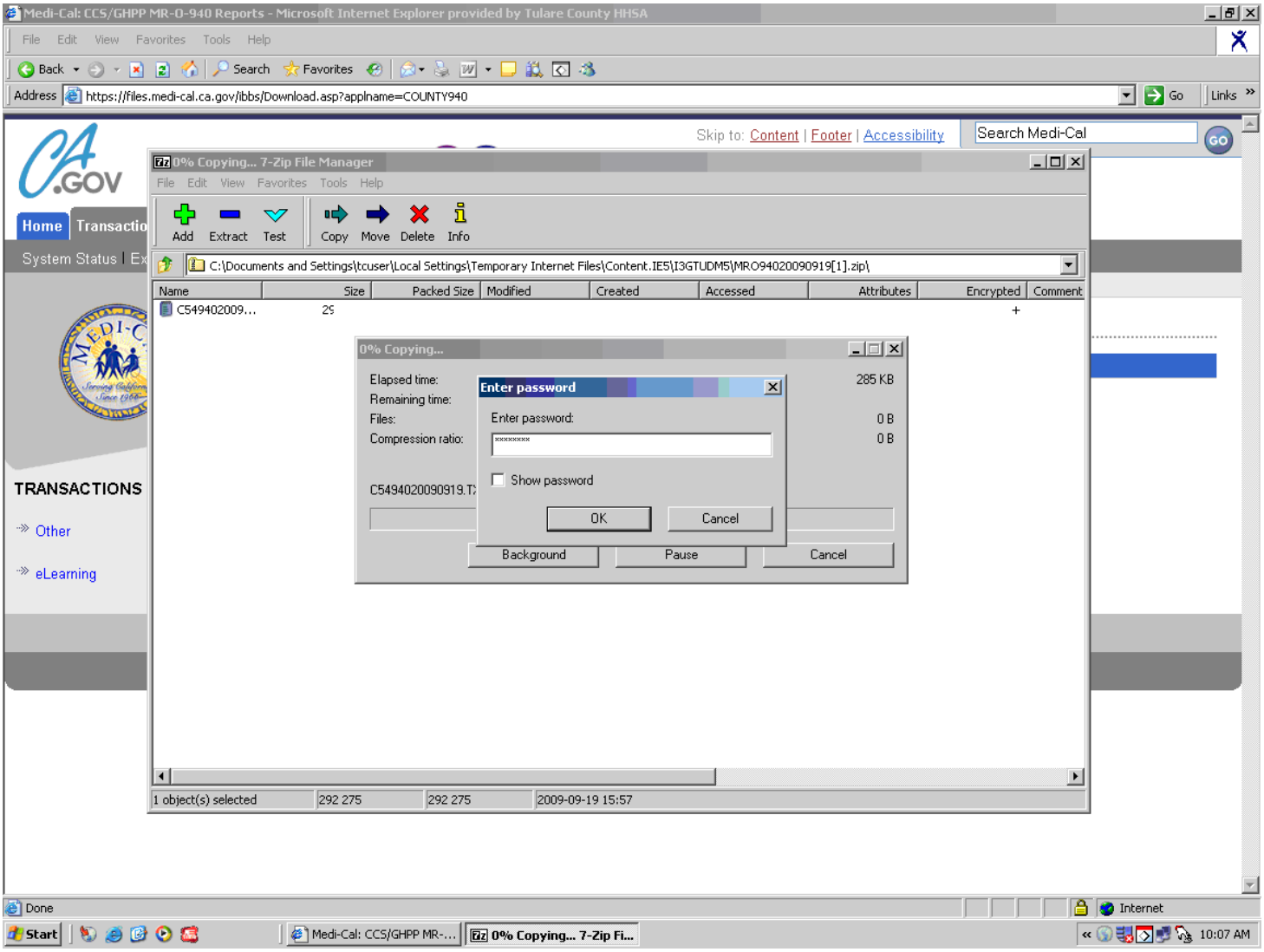
Select either MRO910 or MRO940 Reports

Return to Index



Select the date of the MRO940 report you wish to download

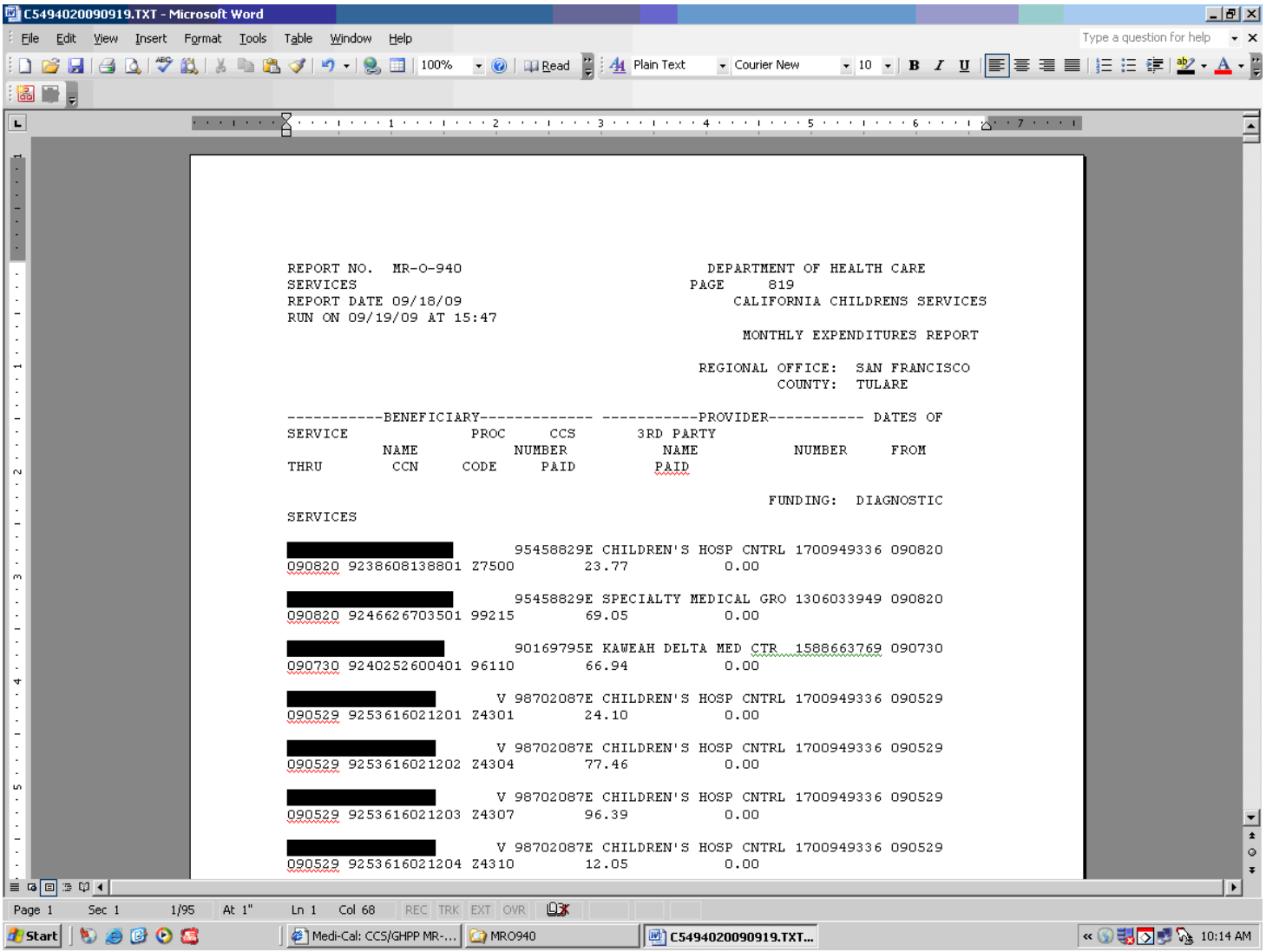
Return to Index



Designate the location where the unzipped* document will be stored and enter your password again to unzip

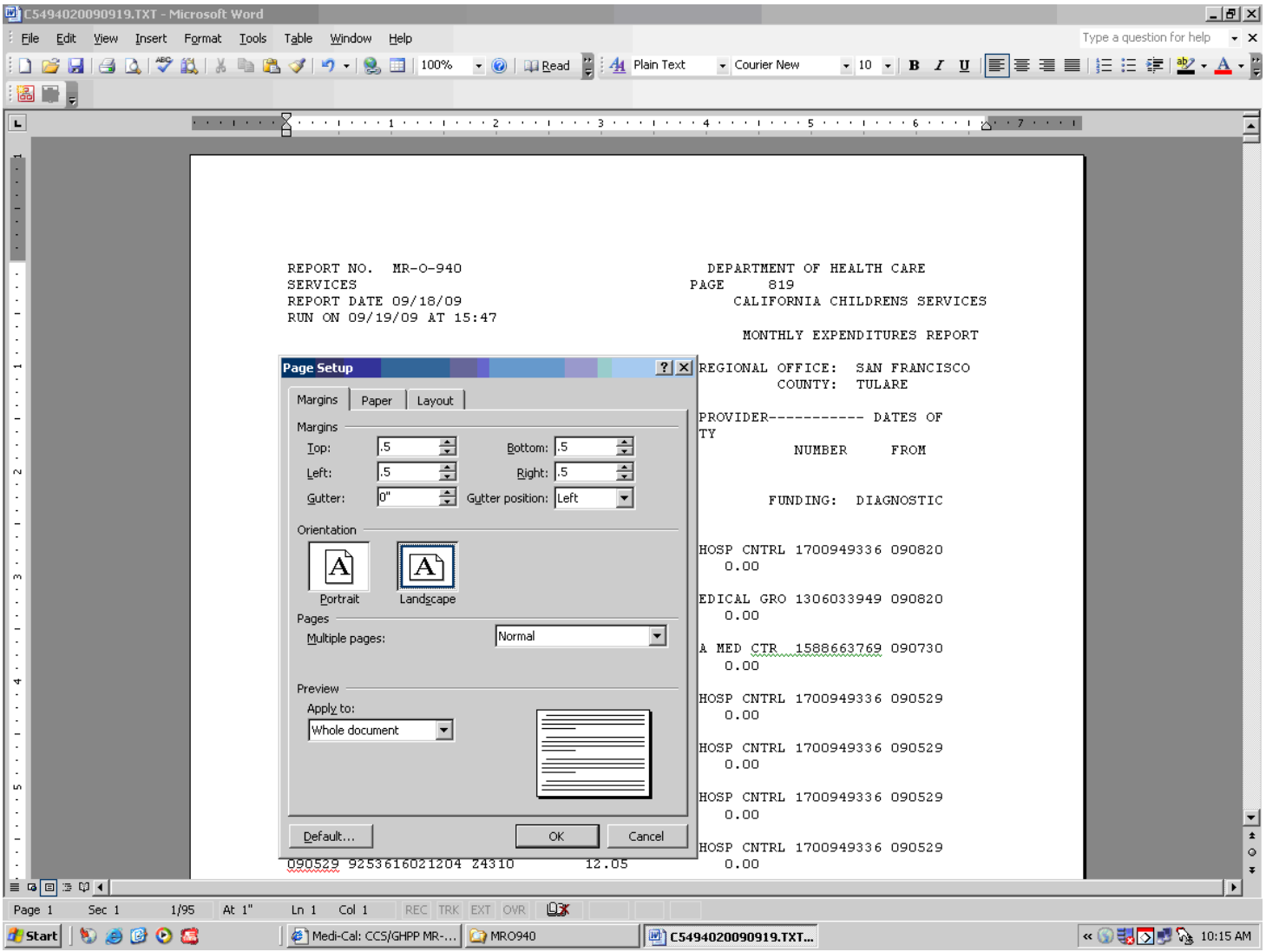
** you must have WinZip, 7-Zip or other compression software to unzip the files*

Return to Index



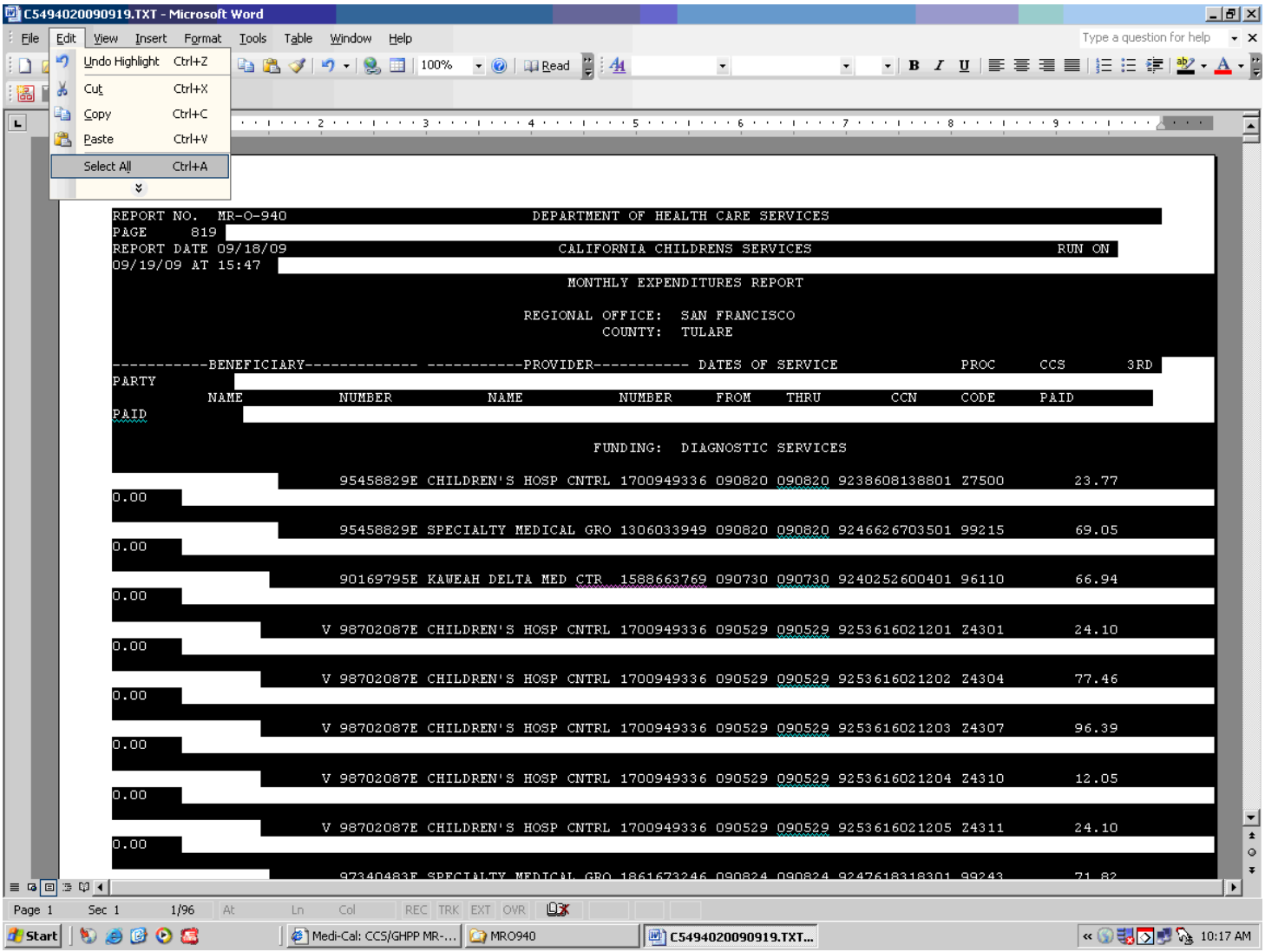
Once you have the file unzipped, open the .txt file into Microsoft Word

Return to Index



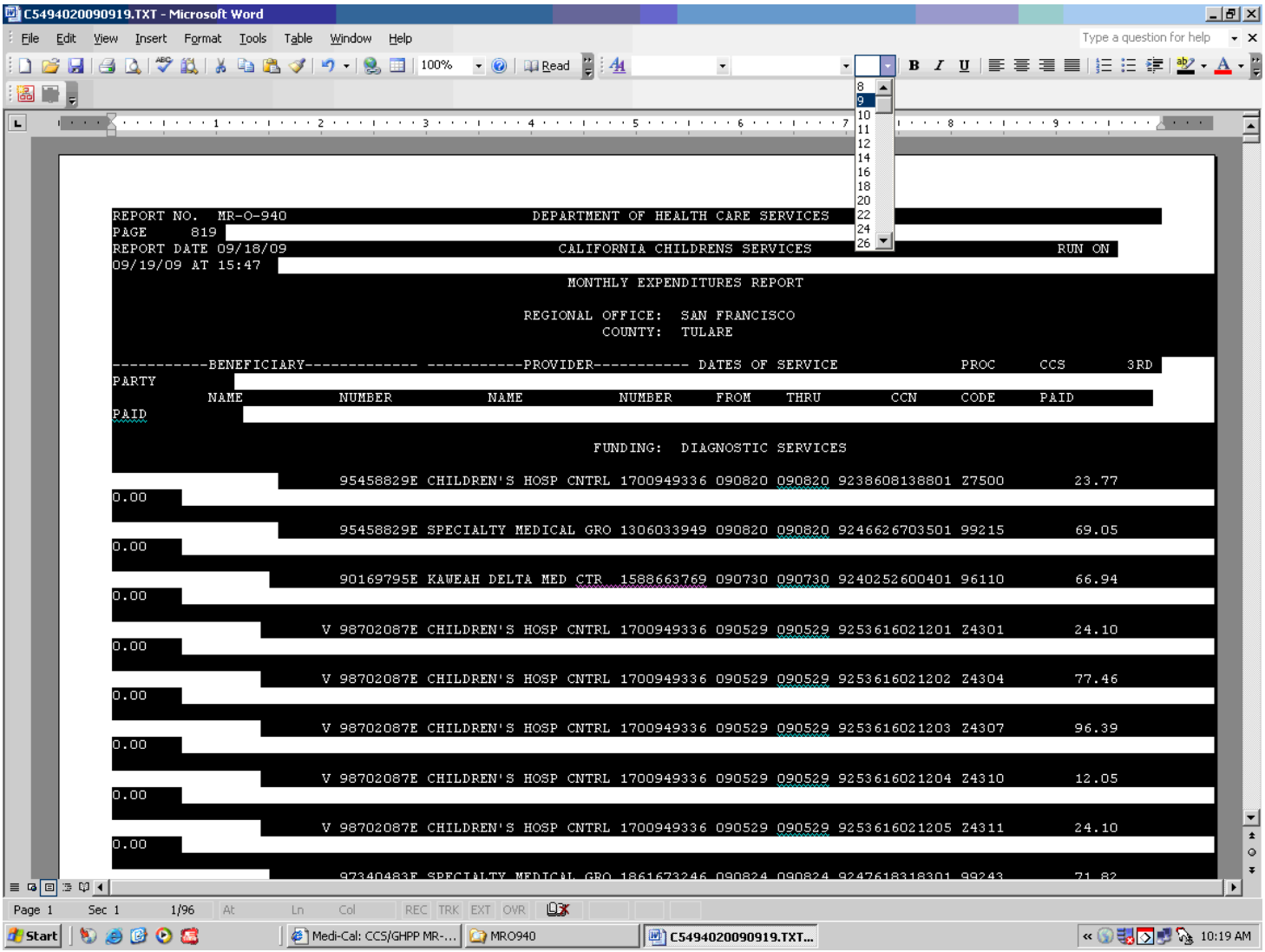
Under page setup, modify the Orientation to Landscape and change all margins to .5 inches

Return to Index



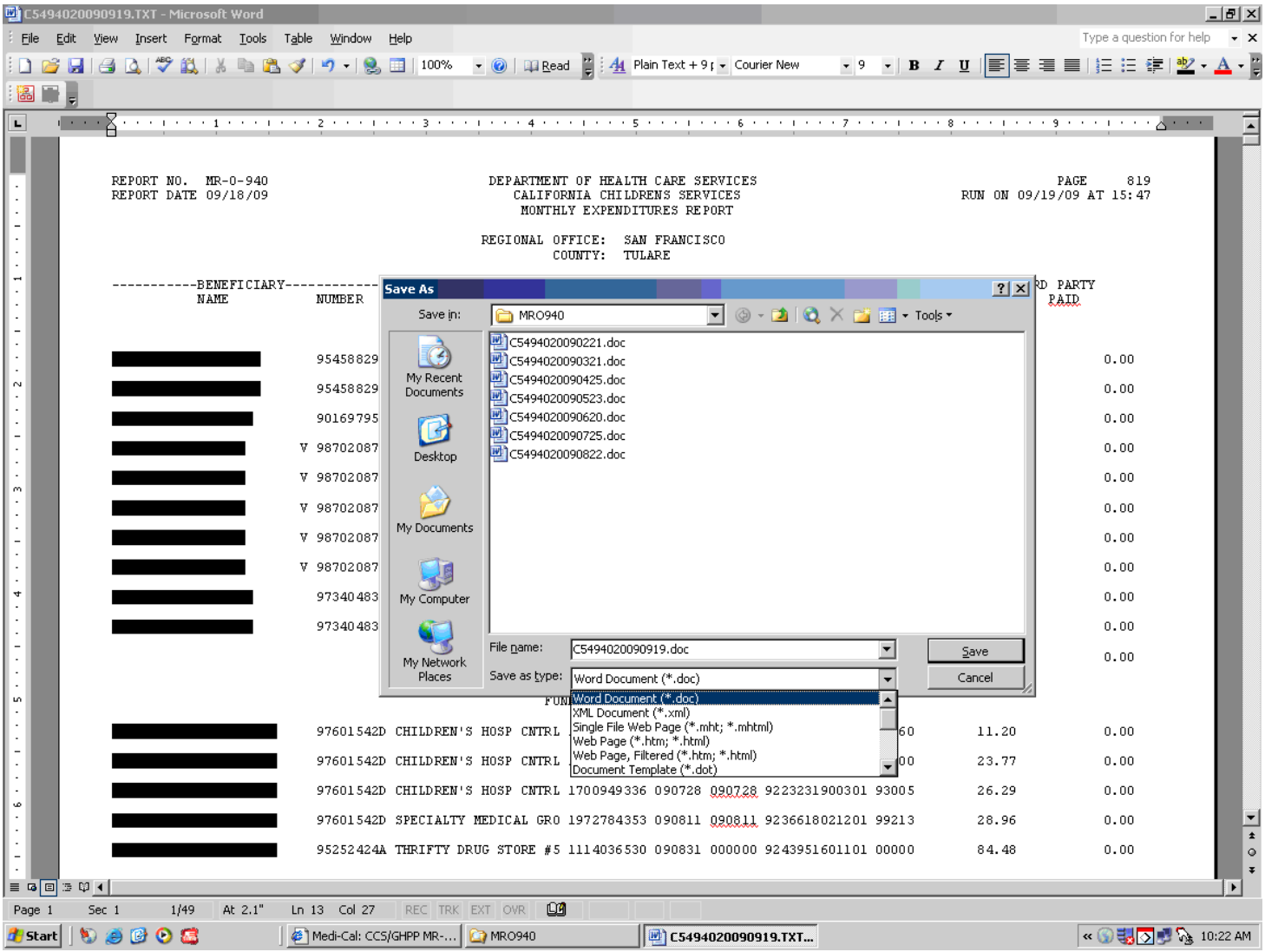
Under Edit, choose Select All

Return to Index



In the font dropdown box, choose 9 pt.

Return to Index



You should now have a formatted Word document that looks identical to the hard copy MRO940 reports

Save as a .doc file

Use the MRO910/MRO940 reports to identify, track and correct errors in claims payment according to N.L. 12-0914.

Return to Index

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 supercede processes that might already be in place in your county. Use this section of the manual along with instructions and forms contained in NL 12-0914.

Tasks should be completed on a regular/daily basis, with tasks spread out throughout the day. When working on several months at a time, work by funding category rather than by month to increase efficiency and reduce re-review of the same client eligibility.

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.
  - Record on Error Log
  - Identify if correction will be via Erroneous Payment Correction (EPC) or Manual Claims Correction Process.
    - See NL 12-0914 to determine if you must wait for an EPC, or if a manual fund source shift will be required.
      - EPC is used for retroactive or not picked up 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 the 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 – Beginning 10/1/15 the OTLICP Federal Matching Rate changed from 65% to 88%. The below equations are only accurate for dates of service from 10/1/15 onward. For prior dates of service replace the 6% with 17.5% to calculate the county share recovery percentage.

Paid Fund Source	Correct Fund Source	County Share Recovery	Explanation (county share math)
Dx	9U: CCS/MC Tr (OTLICP)	44%	50% - 6% = 44%
Dx	9R: CCS/MC 88/12 (OTLICP)	50%	50% - 0% = 50%
Dx	MC	50%	50% - 0% = 50%
Tr	9U: CCS/MC Tr (OTLICP)	44%	50% - 6% = 44%
Tr	9R: CCS/MC 88/12 (OTLICP)	50%	50% - 0% = 50%
Tr	MC	50%	50% - 0% = 50%
9U: CCS/MC Tr (OTLICP)	9R: CCS/MC 88/12 (OTLICP)	6%	6% - 0% = 6%

Return to Index

MR-O-940 CORRECTIONS OF ERRORS PROCEDURES

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 Conduent'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 the State Regional Office 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

State Regional Office 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 the State Regional Office staff the Regional Office 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 Conduent 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 Conduent.

If the error correction(s) is not approved by the State Regional Office staff the Regional Office 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 the State Regional Office 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 Healthy Families Meds Inquiry Screen
- Copy of any other applicable supporting documentation

State Regional Office 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 the State Regional Office staff the Regional Office 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 Correction Transmittal, and all supporting documentation to CMS Fiscal Unit for adjustments.

If the error correction(s) is not approved by the State Regional Office staff the Regional Office 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 your State Regional Office Administrative Consultant or analyst.

Return to Index

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	Full-Scope Medi-Cal, or OTLICP

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

Correct Payment Source	Incorrect Payment Source
Straight-CCS receiving Treatment Services	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 or Healthy Families

FUNDING: HF TRTMENT SERVICES (6% County Funds / 6% State Funds / 88% Federal Funds)

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

FUNDING: HF THERAPY SERVICES (6% County Funds / 6% State Funds / 88% Federal Funds)

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

lieu of MTU)	

FUNDING: HF 65%/35% SERVICES (12% State Funds / 88% Federal Funds) ***No need to check these!***

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

FUNDING: CCS/MEDI-CAL TREATMENT SVCS (6% County Funds / 6% State Funds / 88% 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 (6% County Funds / 6% State Funds / 88% 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 88%/12% SERVICES (12% State Funds / 88% 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 Xerox (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 charged**

Return to Index

Part VII – Resources

Searching On-line for Answers

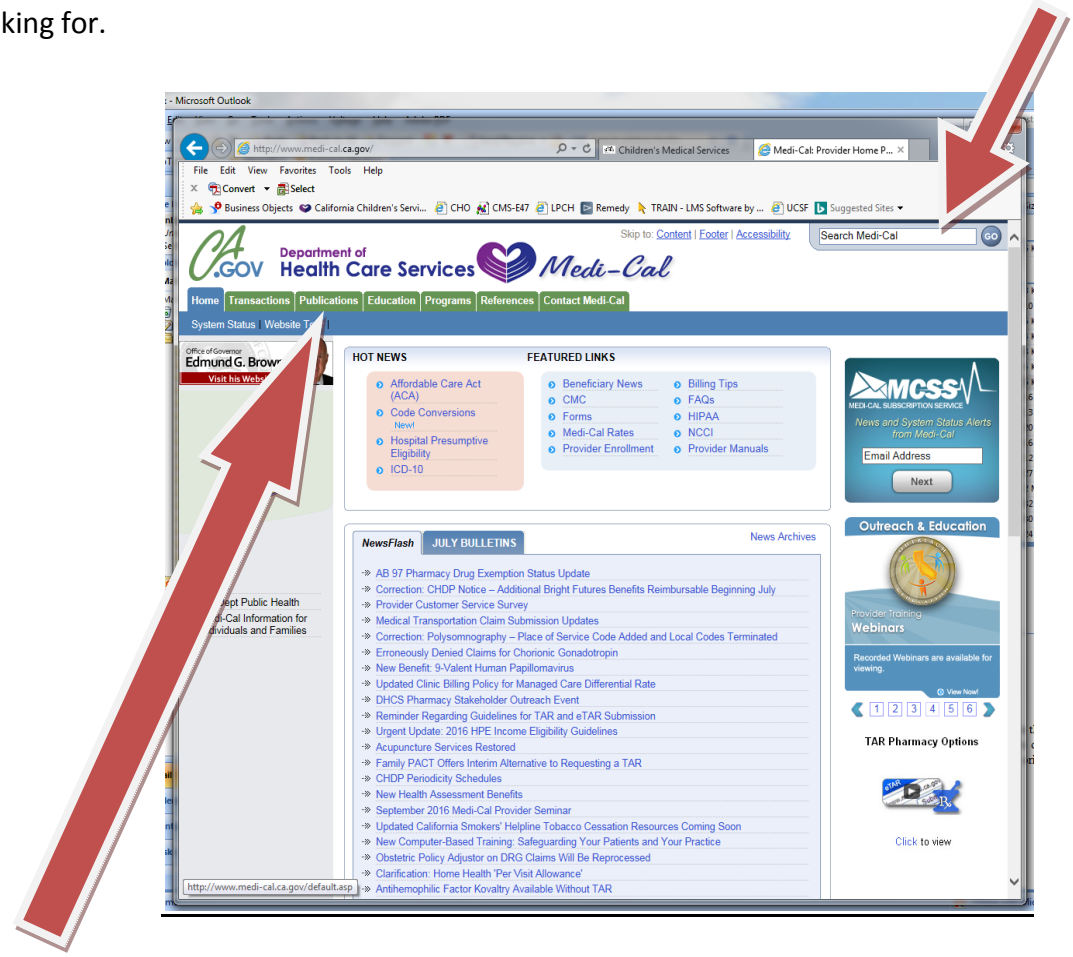
Provider Claim Return Letter

Glossary of CCS Jargon

Searching On-line for Answers

The first place to look for answers is on the DHCS California Children's Services Website in "This Computes," or in a Numbered Letter or Information Notice. A quick way to do this is to enter a key word into the Search Bar at the top right-hand corner of the web-page.

Additionally, 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 the green "Publications" tab.

Tips for using the Medi-Cal search engine:

- less information works best
- Medi-Cal documents are Word documents. You might have to have Word open on your computer for a document to download and open. If it is not opening, look behind windows for a pop-up message. Or, if the Word icon is blinking in your lower toolbar, click on it.

Return to Index

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 (Conduent). Please contact the Medi-Cal help desk at (800) 541-5555 if you have further billing questions. Mail paper claims to Conduent, 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 Xerox for services that CCS has authorized, please contact the local CCS County office at [phone number].

Return to Index

Commonly Used Jargon in the Billing World

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

Conduent – The current DHCS Fiscal Intermediary (FI) is Conduent (formerly ACS Xerox, Formerly HP, formerly EDS). 1-800-541-5555.

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 Conduent.

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 Conduent. 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.

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.

Return to Index

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 Conduent. 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.

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).

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.

Return to Index

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. Providers receive a RAD that 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.

Return to Index

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 Conduent, the Medi-Cal Fiscal Intermediary (FI) (Currently Conduent) 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 Conduent. The other is the CMS-1500 or the Pharmacy 30-1.

Return to Index