SECTION 4: ELIGIBILITY AND CLAIMS

Beneficiary's Eligibility

4.0.0 Initial Eligibility Determination

The MHP will determine beneficiary's Medi-Cal eligibility before referring him/her to a provider for specialty mental health services. Providers who receive direct referrals from other agencies such as Child Protective Services or Foster Care agencies must check Medi-Cal eligibility prior to provision of services. Providers may call the MHP for assistance in determining eligibility.

4.0.1 Subsequent Eligibility Determination

The provider is responsible for determining the beneficiary's subsequent Medi-Cal eligibility. Authorization for services that covers more than one calendar month does not guarantee the beneficiary's eligibility.

4.0.1.1 Determination of Eligibility

At the beginning of each month, the provider must verify and determine the eligibility of beneficiaries who will continue to receive services. This may be accomplished by various methods:

- Automated Eligibility Verification System (AEVS). **Providers must have a Medi-Cal Provider Identification Number (PIN).**
- Point of Service (POS) **device.**
- Internet. **Providers may also access the Medi-Cal Website using the PIN and provider number supplied by the MHP. Information on this website is included at the end of this section.**

The MHP will assist providers who have temporary difficulties verifying eligibility.

Eligibility and Claims

4.1 Claims

4.1.0 Claim Submission **(Revised 7-1-02)**

- **Claims for payment must be submitted on a calendar month basis for all services provided to a beneficiary during that month.** The MHP may deny payment for invoices submitted beyond thirty (30) days of the billing month. **An exception applies to claims billed to third party payers, which are "balanced-billed" to the MHP for Medi-Cal reimbursement. (See 4.2.1, Third Party Insurers.)**

- **Each claim for payment will be for one member only and must include the name of the beneficiary, type of service provided indicated by the MHP service code, date and duration of service and the authorization number.** If the authorization number is not provided or is not valid, the claim will be returned for correction. **(Refer to the MHP Fee Schedule provided at the end of this section).** The MHP service codes must be used in lieu of HCPCS/CPT codes.

- **Providers must use the HCFA-1500 form to submit all claims for services provided. Please see example of a completed HCFA-1500 form at the end of this section indicating all required information. Completion instructions are also included.**

- **Remit all claims to:**
  Fresno County Mental Health Plan
  Attn: Claims
  P.O. Box 45003
  Fresno, CA 93718-9886

4.1.1 Claims / Billing Audit

Each claim/billing is subject to audit for compliance with federal and state regulations.

4.1.2 Disapproved Claims

In the event that a claim is disapproved by the MHP, Fresno County may withhold compensation or, if already paid, set off from future payments due, the amount of the disapproved billings.

Provider May NOT:

- **Bill in his/her name for treatment provided by another practitioner or an assistant.**
- **Bill the beneficiary for amounts over the contracted rate.**

4.2 Beneficiaries with Share of Cost or Third Party Insurers

4.2.0 Share of Cost **(Revised 7-1-02)**

Depending on a beneficiary's monthly income, Medi-Cal may determine that he/she must meet a share of cost (SOC) before Medi-Cal will pay for medical expenses. Therefore, the beneficiary may not be eligible for Medi-Cal covered benefits until the SOC is met.

The provider is responsible for collecting the SOC amount from the beneficiary and for clearing this amount from the beneficiary's account. The provider will bill the MHP only for the difference between the SOC collected and the MHP contract rate. Please refer to the HCFA 1500 example at the end of this section on how to report SOC amounts.

4.2.1 Third Party Insurers **(Revised 7-1-02)**

Medi-Cal is the payer of last position. The provider must bill the beneficiary for his/her authorized SOC and any third party insurers before requesting payment from the MHP. The MHP will only reimburse the difference between the MHP service rates and the payment amount by the primary payer, minus the SOC. The total reimbursement will not exceed the MHP's service rate schedule.

(New 7-1-02)

Medi-Cal Beneficiaries with Medicare A & B or B Only Coverage

Providers treating Medi-Cal beneficiaries that also have Medicare A & B or B only coverage must submit claims directly to Medicare. Medi-Cal and the MHP are not responsible for outpatient or professional services with these types of Medicare coverage.

To submit a Medi-Cal claim for a beneficiary with a third party payer, the provider must:

- **submit a claim to the MHP along with a copy of the third party payer denial letter or Explanation of Benefits (EOB)** within 30 days **of the date of the denial or EOB.**

However, if provider does not receive an EOB or denial from the third party payer within two (2) months from the month of service, the provider must:

- **contact the third-party payer and inquire as to the status of the claim.**
- **submit the Medi-Cal claim** and **a copy of the claim, that was submitted to the primary insurance, to the MHP within two (2) months from the month of service.**

4.3 Payment Policies

Payment will be authorized for valid claims for specialty mental health services if:

- **Services were pre-authorized by the Authorization Unit of the MHP;**

- **Services were delivered by a contract provider, and were within the range of pre-selected service codes allowed by scope of practice and contract agreements;**

- **Beneficiary was Medi-Cal eligible at the time services were provided; following the initial authorization, it is the provider's responsibility to assure that services are provided to eligible beneficiaries.**

Terms of payment are as follows:

- **Payment will be based on the prevailing MHP fee schedule. Reimbursement will be determined by the terms of the agreement. Prevailing reimbursement rates shall be considered payment in full, subject to third party liability and beneficiary share of cost for the specialty mental health services.**

- **The MHP pays the provider in arrears, within 45 days after receipt and verification of provider's invoices by the MHP.**

- The MHP will not pay for sessions for which a beneficiary fails to show.

Specialty mental health services provided to a beneficiary with an emergency psychiatric condition do not require pre-authorization.

4.4 Beneficiary Who Loses Medi-Cal Benefits During an Authorization Period

A Medi-Cal beneficiary who becomes ineligible for Medi-Cal benefits during an authorization period may continue to receive services. However, the provider must notify the beneficiary and the MHP that eligibility has changed. The MHP will determine the best treatment plan which may include authorizing continued services to ensure continuity of care and minimize disruption of services or transition the client back to the County as appropriate.

Claims/Billing inquiries may be made by calling a Provider Relations Specialist at 1-888-262-4174.

Fresno County Mental Health Plan

Individual & Group Provider Fee Schedule

Effective 9-1-02

Service Description	Service Code	Rate Effec 9/1/02
Psychiatrist		
Individual Assessment (30 min.)	90841F	**$ 36.00**
Individual Assessment (60 min.)	90842F	**76.00**
Individual Medical Psychotherapy (30 min.)	90843F	**36.00**
Individual Medical Psychotherapy (60 min.)	90844F	**76.00**
Pharmacological Management (15 min.)	90862F	**28.00**
Pharmacological Management-Board Cert./Elig.Child Psychiatrist	90863F	**45.00**
Hospital Care - Inpatient - New/Estabished (60 min.)	99223F	**90.00**
Hospital Care - Subsequent - Bedside (30 min.)	99232F	**50.00**
Inpatient Consultation - Initial - New/Established (60 min.)	99253F	**76.00**
Emergency Dept. (30 min.)	99283F	35.00
Nursing Facility Assessment (60 min.)	99303F	**85.00**
Subsequent Nursing Facility (15 min.)	99311F	**25.00**
Subsequent Nursing Facility (30 min.)	99312F	**45.00**
Group Therapy	X9506F	**23.00**
Family Therapy (60 min)	X9508F	**57.00**
Collateral (15 min.)	X9543F	**15.00**
Case Management/ Linkage & Consult (15 min)	X9205F	10.00
Psychologist		
Individual Assessment (60 min.)	X9504F	**$ 57.00**
Individual or Family Psychotherapy (30 min.)	X9600F	**28.00**
Individual or Family Psychotherapy (60 min.)	X9601F	**57.00**
Group Therapy	X9506F	**23.00**
Test Administration Including Pre-Interview (120 min.)	X9516F	**104.00**
Test Administration Including Pre-Interview (180 min.)	X9518F	**156.00**
Collateral (15 min.)	X9543F	**15.00**
Case Management/ Linkage & Consult (15 min)	X9205F	10.00
LCSW, LMFT, RN - MS		
Individual Assessment (60 min.)	X9504F	**$ 57.00**
Individual or Family Psychotherapy (30 min.)	X9600F	**28.00**
Individual or Family Psychotherapy (60 min.)	X9601F	**57.00**
Group Therapy	X9506F	**23.00**
Collateral (15 min.)	X9543F	**15.00**
Case Management/ Linkage & Consult (15 min)	X9205F	10.00

Services for Court Referred Cases

Psychologist		
Psychological Evaluation I (8 hours Maximum)	X9504F	**$ 57 / Hr**
Psychological Evaluation II (10 hours Maximum)	X9504F	**$ 57 / Hr**
All Disciplines		
Bonding Study I or II (10 hours maximum)	X9504F	**$ 57 / Hr**
Family Psychodynamic Formulation (10 hours maximum)	X9504F	**$ 57 / Hr**
Attachment Assessment (10 hours maximum)	X9504F	**$ 57 / Hr**
Quarterly Report (per report)	QR	40.00
Court Report (per report)	CR	54.00
Court Testimony (per hour of testimony)	CT	54.00

Revised: 8/12/02

Fresno County Mental Health Plan

Specialty Mental Health Services

Allowable ICD-9 / DSM-IV Diagnosis Codes

Outpatient Services
295.00 - 298.9
299.1 - 300.89
301.0 - 301.6
301.8 - 301.9
302.1 - 302.6
302.8 - 302.9
307.1
307.3
307.5 - 307.89
308.0 - 309.9
311 - 313.82
313.89 - 314.9
332.1 - 333.99*
787.6

Hospital Inpatient Services
290.12 - 290.21
290.42 - 290.43
291.3
291.5 - 291.89
292.1 - 292.12
292.84 - 292.89
295.00 - 299.00
299.10 - 300.15
300.2 - 300.89
301.0 - 301.5
301.59 - 301.9
307.1
307.20 - 307.3
307.5 - 307.89
308.0 - 309.9
311 - 312.23
312.33 - 312.35
312.4 - 313.23
313.8 - 313.82
313.89 - 314.9
787.6

* Treatment of diagnoses 332.1-333.99, Medication Induced Movement Disorder, is a covered service only when the Medication Induced Movement Disorder is related to one or more included diagnoses.

Revised 9/4/2000

HCFA 1500 – Completion Instructions

REQUIRED INFORMATION

Box #1a Insured's correct Medi-Cal Identification Number/Social Security Number.

Box #2 Consumer's Full Name as recognized by Medi-Cal or as indicated on their Benefit Identification Card (BIC), last name, first name and initial (if applicable).

Box #3 Correct Date of Birth and Gender (male or female).

Box #5 Complete home address and telephone number.

Box #11 Enter the Eligibility Verification Confirmation (EVC) Number, Month/Year and any Share of Cost (SOC) amount.

Box #11d Is there another Health Benefit Plan? If so, Provider is to bill the carrier and then submit a Medi-Cal claim with a copy of the Denial letter or Explanation of Benefits (EOB) **within 30 days** of the date of the denial or EOB.

Box #12/13 Patient's signature or noted that signature is "On File".

Box #21 Diagnosis #1 **must** be an included diagnosis code or a "rule-out" diagnosis for assessments.

Box #23 The Authorization number **must** be provided or attach a copy of the authorization. Enter "Assessment #1 or #2" if applicable. Also indicate if consumer is Youth Link (YL) or CalWorks (CW).

Box #24

a) Date of Service must match date in chart notes.
b) Place of Service.
d) FCMHP Service Codes must be those on the Provider Fee Schedule.
e) Diagnosis must equal item #1 in Box 21.
f) Charges should not be less than reimbursable rate.
g) Units must be correct.

Box #25 Federal Tax ID Number is required as indicated in Provider Contract.

Box #28 Total of all charges.

Box #29 Indicate the SOC amount (whether collected or not collected).

Box #30 Balance Due = Total charge less SOC.

Box #31 Original signature required of Provider or authorized biller for the Provider.

Box #32 Name and Address of Facility where services were rendered is required for Inpatient Claims or outpatient services as appropriate.

Box #33 Provider or Group Name and complete address with telephone number.

APPROVED OMB-0938-0008

EXAMPLE ONLY

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 553-89-2258

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): DOE, JOHN

3. PATIENT'S BIRTH DATE MM DD YY: 10 16 73 SEX: M [X] F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1425 N. Briarwood Avenue

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Fresno STATE: CA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 93728 TELEPHONE (Include Area Code): (559) 439-0974

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: D482809289 12/98 SOC = $20.00

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature "On File" DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 309 01
2.
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: Auth# or Assessment# and "YL" or "CW" if applicable

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 01 02			11	X9504F		1	60.00	1				
2 07 10 02			11	X9504F		1	60.00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 551-99-0691 ☐

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE: $ 120.00

29. AMOUNT PAID: $ 20.00=SOC

30. BALANCE DUE: $ 100.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED: DATE: 7-1-02

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Facility Name & Address
(if applicable)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Daniel T. Owen, PhD
6843 N. Tielman
Fresno, CA 93710 271-4389

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

MENTAL HEALTH PLAN (MHP)

PLACE OF SERVICE. Enter one code from the list below indicating where the service was rendered:

Code	Place of Service
11	Office
12	Patient's Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgical Center
25	Birthing Center
31	Skilled Nursing Facility
32	Nursing Home/Nursing Facility
41	Ambulance (Land)
42	Ambulance (Air or Water)
53	Community Mental Health Center
54	Specialized Treatment Center/Intermediate Care Facility-Nursing/Mentally Retarded
55	Residential Treatment Center/Substance Abuse
62	Comprehensive Outpatient Rehabilitation Facility
65	Independent Kidney Disease Treatment Center
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
91	Adult Subacute Care
92	ICF-DD
93	ICF-DDH
96	Pediatric Subacute Care
97	Transitional Care
99	Other

Medi-Cal AID Codes

Code	Pay
0A	YES
0M	YES
0N	YES
0P	YES
0R	NO
0T	NO
0U	NO
01	YES
02	YES
03	YES
04	YES
07	NO
08	YES
1H	YES
1U	NO
10	YES
13	YES
14	YES
16	YES
17	YES
18	YES
2A	YES
20	YES
23	YES
24	YES
26	YES
27	YES
28	YES
3A	YES
3C	YES
3E	YES
3G	YES
3H	YES
3L	YES
3M	YES
3N	YES
3P	YES

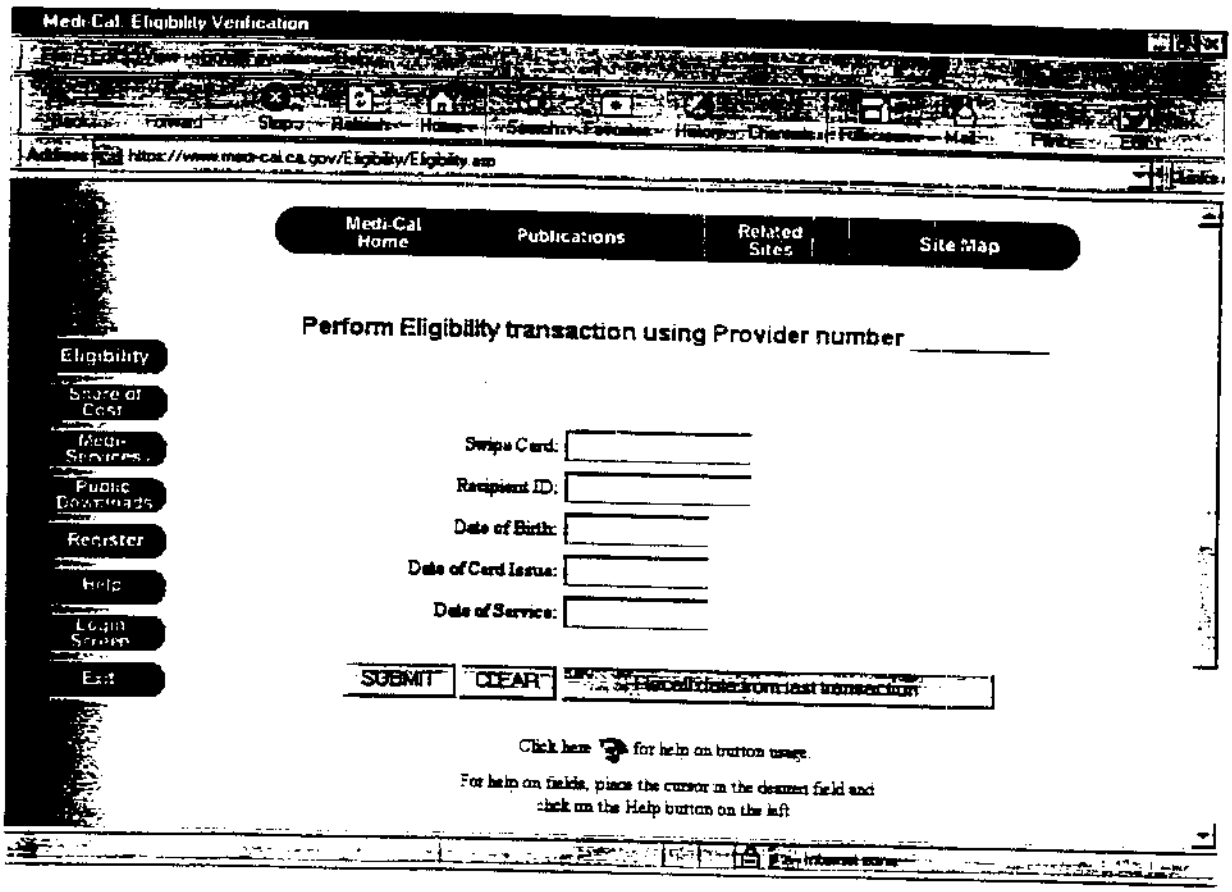
Code	Pay
3R	YES
3T	NO
3U	YES
3V	NO
3W*	**YES**
30	YES
32	YES
33	YES
34	YES
35	YES
36	YES
37	YES
38	YES
39	YES
4A	YES
4C	YES
4F	YES
4G	YES
4K	YES
4M	YES
40	YES
42	YES
44	NO
45	YES
47	YES
48	NO
5F	NO
5J	NO
5K	YES
5R	NO
5T	NO
5W	NO
5X	YES
5Y	NO
50	NO
53	NO
54	YES

Code	Pay
55	NO
58	NO
59	YES
6A	YES
6C	YES
6G	YES
6H	YES
6J	YES
6N	YES
6P	YES
6R	YES
6U	NO
6V	YES
6W	YES
6X	YES
6Y	YES
60	YES
63	YES
64	YES
65	YES
66	YES
67	YES
68	YES
69	NO
7A	YES
7C	NO
7F	NO
7G	NO
7H	NO
7J	YES
7K	NO
7M	NO
7N	NO
7P	YES
7R	**NO***
7T*	**YES**
7X	YES

Code	Pay
70	NO
71	NO
72	YES
73	NO
74	NO
75	NO
76	NO
79	**YES***
8E	YES
8F	NO
8G	YES
8H	NO
8N	NO
8P	YES
8R	YES
8T	NO
80	NO
81	YES
82	YES
83	YES
84	NO
85	NO
86	YES
87	YES
88	NO
89	NO
9A	NO
9H	NO
9J	NO
9K	NO
9M	NO
9N	NO
9R	NO

Eligibility on the Internet

E-business has never been so quick and easy!



www.medi-cal.ca.gov

Recipient eligibility on the Internet

Eligibility verification is a new Provider Services offering on the Medi-Cal Web site.

Providers with a valid provider number and PIN can access a Web page to verify recipient eligibility, and perform Medi-Service, Share of Cost and Family PACT transactions.

Providers can perform these transactions with confidence. Recipient and provider information is protected by powerful electronic security measures using industry-standard technology.

Questions? Providers can use the pop-up Help windows or view the *Quick Start Guide* on the Medi-Cal Web site. The POS/Internet Help Desk is also available for technical assistance at 1-800-427-1295.

Eligibility on the Internet — another business solution from Medi-Cal.

AEVS: General Instructions 1

The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows you the ability – through a touch-tone telephone – to access recipient eligibility, clear Share of Cost liability and/or reserve a Medi-Service.

Recipient eligibility verification information is available for Medi-Cal, County Medical Services Program (CMSP) and Family PACT. Recipient eligibility for the Child Health and Disability Prevention (CHDP) program, the California Children Services (CCS) program or the Genetically Handicapped Persons Program (GHPP) is not available.

There is no enrollment requirement to participate in AEVS. Providers must use a valid Provider Identification Number (PIN) to access AEVS. The PIN is issued when providers enroll with Medi-Cal. If the PIN is unknown, providers should complete and return the *Provider Identification Number (PIN) Reissue Request* form at the end of the *Provider Telecommunications Network (PTN)* section in this manual.

For questions about…	**Call…**
Operation of AEVS	POS Help Desk 1-800-427-1295
Medi-Cal Policy	Provider Support Center (PSC) 1-800-541-5555
Family PACT	Health Access Programs (HAP) 1-800-257-6900

GENERAL INFORMATION

Edit Conditions

Use of AEVS does not guarantee that the claim will be paid. All existing edit conditions – such as service restrictions, SOC certification, provider eligibility or prior authorization requirements – must still be satisfied.

Transactions Available

AEVS verifies a recipient's eligibility for the current and/or prior 12 months; provides information on SOC, Other Health Coverage, and Prepaid Health Plan (PHP) status; identifies any service restrictions placed on that recipient; clears SOC liability; and allows podiatrists and certain allied health providers to reserve Medi-Services.

BIC Card

When a recipient presents a plastic Medi-Cal Benefits Identification Card (BIC), recipient eligibility must be verified. BICs are not a guarantee of Medi-Cal, CMSP or Family PACT eligibility because they are a permanent form of identification and recipients retain the cards even if they are not eligible for Medi-Cal, CMSP or Family PACT during the current month.

HAP Card

A Health Access Programs (HAP) card is issued and activated by the provider after the client has completed and signed a *Health Access Programs State-Only Family Planning Program Client Eligibility Certification* form. HAP cards are not a guarantee of Family PACT eligibility because they are a permanent form of identification and clients retain the cards even if they are not eligible for Family PACT during the current month.

Eligibility Verification Confirmation (EVC) Number

AEVS accesses the most current recipient information for a specific month of eligibility. AEVS returns a 10-character EVC number, after eligibility is confirmed. It is recommended to enter in the EVC number in the remarks area of the claim. However, the EVC number is not required information for claim processing.

Note: An Eligibility Verification Confirmation (EVC) number is only valid for the provider who submitted the inquiry.

Unmet Share of Cost

If the recipient has an unmet SOC, no EVC number is given unless the recipient is dually eligible (eligible for services under more than one aid code). For a dually eligible recipient, who is eligible for certain services with no SOC and the remaining services with a SOC, the aid code and corresponding eligibility message and an EVC number are given in the eligibility response for the non-SOC aid code only. An SOC message is then given for the SOC aid code.

Important: To avoid having a claim deny for recipient eligibility, the claim must be submitted with the same provider number, recipient ID and date of service used for the AEVS inquiry.

ACCESSING TELEPHONE AEVS

Introduction

Before you access telephone AEVS, you should have the required information ready to enter using your touch-tone telephone when prompted by AEVS.

Time Limit

Telephone AEVS allows you a specified amount of time following each prompt to enter information using your touch-tone telephone. If you fail to respond to a prompt within five seconds, AEVS will remind you up to three times. If you have not entered any information after the third reminder, you will "time out" and AEVS will terminate the call with the following message:

> *"We're sorry, we are unable to complete your call. Please review the procedures in your AEVS User Guide or AEVS section of your provider manual. If you have any questions concerning AEVS, please contact the POS Help Desk at 1-800-427-1295. Denti-Cal providers should call 1-800-423-0507. Thank you for calling the Automated Eligibility Verification System. Good-bye."*

Error Limits

When entering required information using your touch-tone telephone, AEVS will allow you three opportunities to correctly enter the information. Upon your first and second error, AEVS will prompt you to re-enter the information correctly. After the third error, AEVS will terminate your call with the following message:

> *"We're sorry, we are unable to complete your call. Please review the procedures in your AEVS User Guide or AEVS section of your provider manual. If you have any questions concerning AEVS, please contact the POS Help Desk at 1-800-427-1295. Denti-Cal providers should call 1-800-423-0507. Thank you for calling the Automated Eligibility Verification System. Good-bye."*

Documenting Eligibility Information

Following receipt of AEVS eligibility information, note the information for future reference when completing your claim forms. Be prepared to write down the eligibility information for each inquiry as it is given to you over the telephone. AEVS will give an Eligibility Verification Confirmation (EVC) number for each inquiry that receives an eligible response.

Providers verifying eligibility information for Medi-Cal recipients may want to use the *AEVS Response Log* to track AEVS transactions. This form is located at the end of the *AEVS: Transactions* section in this manual.

The EVC number should be noted in your patient's records for future reference. AEVS will provide you with the option to repeat eligibility information and the verification code as needed to ensure that you record the information accurately.

Hours of Operation

Telephone AEVS is available by using a touch-tone telephone between 2 a.m. and midnight, seven days a week. If you attempt to access telephone AEVS during non-operational hours, you will receive the following message:

> *"The Medi-Cal Automated Eligibility Verification System is available between 2 a.m. and midnight. Please call back during these hours of operation. Thank you for calling the Automated Eligibility Verification System. Good-bye."*

In the unlikely event that telephone AEVS is unavailable during normal hours of operation, you will receive the following message when you attempt to verify eligibility for Medi-Cal or County Medical Services Program (CMSP) recipients:

> *"The Medi-Cal Automated Eligibility Verification System is currently unavailable. Please call back later. Thank you for calling the Medi-Cal Automated Eligibility Verification System. Good-bye."*

If AEVS is not available when you attempt to access Family PACT transactions, you will receive the following message:

> *"The State-Only Family Planning system is currently unavailable. Please report your problem to the POS Help Desk at 1-800-427-1295."*

Inquiry Limitations

To ensure optimal availability of telephone AEVS, providers are limited to a maximum of 10 inquiries for each telephone call. An inquiry is any request that is sent to the Medi-Cal eligibility verification system. For example, if verification is requested for a single recipient for the current month and three previous months, that is considered four inquiries. If the Medi-Cal eligibility verification system tells you that you have made an error and you resubmit the transaction, that is considered two inquiries. An inquiry for eligibility for one recipient and a Share of Cost clearance for another recipient is considered two inquiries. Any combination of inquiries, to a maximum of 10, are allowed per telephone call.

"Bypass" Procedures

After you have become accustomed to the system and the prompt messages, you may choose to "bypass" listening to the entire prompt. To use the "bypass" feature, enter the appropriate data after the beginning of each prompt.

Star Key (*)

The star key (*) has a variety of functions:

Repeat Previous Prompt

[* #] Pressing the star key followed by the pound sign key [* #] will cause AEVS to repeat the previous prompt.

Deleting Entered Data	[* *]	To delete all entered data in a current field, press two successive star keys, then enter the correct data. For example, if you intended to enter "12345" but accidentally keyed "12567", the mistake can be corrected by entering [* *] followed by the correct data. The sequence of keystrokes would be: 12567* *12345 # By pressing [#] you end the data entry. When AEVS receives the input, it discards all data in the field preceding the double star and takes the data following the double star as the intended input. The final input to AEVS would be "12345".
Return To Main Menu	[* 99 #]	Pressing the star key, followed by "99", followed by the pound sign key [* 99 #] will return you to the main menu and you will hear the following: *"To perform an Eligibility Verification, press 1. To perform a Share of Cost transaction, press 2. To perform a Medi-Service transaction, press 3. To perform a State-Only Family Planning program transaction, press 4. To end this call, press 5."*
Help Prompt	[* 4 #]	Pressing the star key, followed by "4", followed by the pound sign key [* 4 #] will cause AEVS to speak the following message: *"Special touch-tone features exist for this application. To repeat the previous prompt, press star pound [* #]. To void data entered, press star star [* *] and re-enter the correct data. To go to the main menu, press star nine nine pound [* 99 #]. Press star four pound [* 4 #] to hear this help message any time during your call."*

ENTERING ALPHABETIC DATA

Introduction

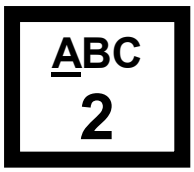
To enter alphabetic data (letters A, B, C, etc.), press the star key (*) followed by a two-digit code representing the letter. This function is used when entering some Medi-Cal identification numbers or procedure codes with alphabetic characters.

Two-Digit Code

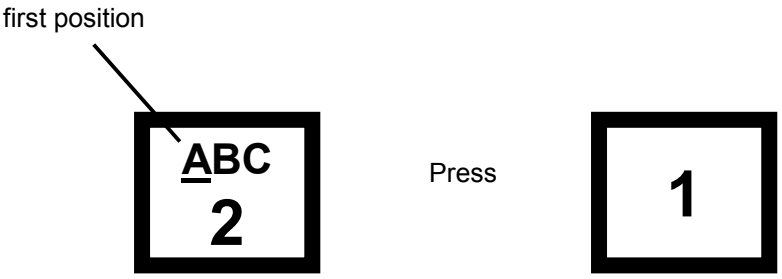
The first digit of the code for all letters (except "Q" and "Z") is the keycap on which the letters appear. The second digit of the code identifies the letter's corresponding position on the appropriate keycap.

To enter the first digit of the code, press the keycap on which the letter appears. To enter the second digit of the code for the letter, find the position of the letter on the keycap (first, second or third position) and press the corresponding keycap representing the position (**[1]**, **[2]** or **[3]**).

For example, to enter the two-digit code for the letter "A," first press the star key (*), then press **[2]** keycap to identify "A":



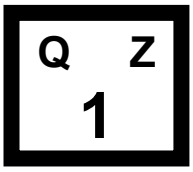
Then press the **[1]** keycap to identify the first position:



Therefore, the two-digit code for the letter "A" is *** 21**.

Alphabetic Codes "Q" and "Z"

Since the letters "Q" and "Z" do not appear on any keycap of the touch-tone keypad, these two letters are treated as though they are the first two letters on keycap **[1]**.

Press 

for characters Q and Z

To enter "Q," press (*) plus **[1]** to identify the letter "Q" and **[1]** to show that "Q" is in the first corresponding position on the keycap. Therefore, the two-digit code for the letter "Q" is *** 11**.

To enter "Z," press (*) plus **[1]** to identify the letter "Z" and **[2]** to show that "Z" is in the second corresponding position on the keycap. Therefore, the two-digit code for the letter "Z" is *** 12**.

14-digit Medi-Cal ID

To enter the 14-digit Medi-Cal Identification Number "443**C**5213910234" you would identify the letter "C" by entering the following two-digit code (including the required star):

C = *** 23**

Therefore, the touch-tone entry for "443**C**5213910234" would be "443***23**5213910234".

9-digit ID Number

To enter the 9-digit ID Number "444-55-611**P**" you would identify the letter "P" by entering the following two-digit code (including the required star):

P = *** 71**

Therefore, the touch-tone entry for "444-55-611**P**" would be "44455611***71**".

HCPCS Codes

To enter the HCPCS code "**Z**2345" you would identify the letter "Z" by entering the following two-digit code (including the required star):

Z = *** 12**

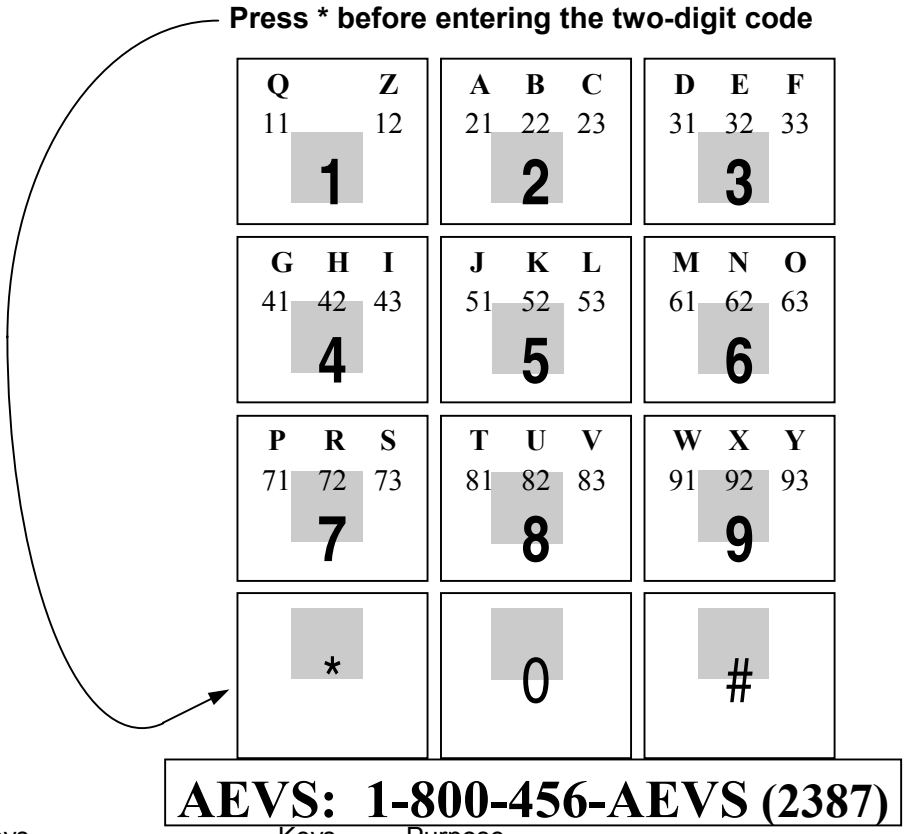
Therefore, the touch-tone entry for "**Z**2345" would be "***12**2345".

List of Alphabetic Codes

The alphabetic code listing for AEVS is as follows:

LETTER	2-DIGIT CODE	LETTER	2-DIGIT CODE
A	* 21	N	* 62
B	* 22	O	* 63
C	* 23	P	* 71
D	* 31	Q	* 11
E	* 32	R	* 72
F	* 33	S	* 73
G	* 41	T	* 81
H	* 42	U	* 82
I	* 43	V	* 83
J	* 51	W	* 91
K	* 52	X	* 92
L	* 53	Y	* 93
M	* 61	Z	* 12

Alphabetic Code Listing



Function Keys

Keys	Purpose
[#]	End data entry in a field; proceed to next field
[* #]	Repeat the menu option
[* *]	Delete the current data entry in a field
[* 99 #]	Return to the main menu

AEVS: Transactions 1

This section describes how to access the Medi-Cal eligibility verification system and complete eligibility verifications.

Also included at the end of this section is the *AEVS Response Log.* This is designed to be photocopied for use in tracking AEVS transactions. The log was created as a convenient means of maintaining provider records only. It does not serve as valid proof of eligibility for claim submissions or appeals. It is recommended that you have this form available when you access AEVS.

GENERAL INFORMATION

Provider Identification Number (PIN)

Using a touch-tone telephone, dial **1-800-456-AEVS (2387)**. AEVS will respond with the following message:

> *"Welcome to the Medi-Cal Automated Eligibility Verification System, also referred to as A-E-V-S. Please enter your Provider Identification Number followed by a pound sign (#)."*

Enter your Provider Identification Number (PIN). AEVS will respond with the following message:

> *"Please wait while the requested information is retrieved."*

If the PIN cannot be found on the Provider Master File, AEVS will prompt you to re-enter the correct PIN. If the PIN cannot be found after the second try, the call will be terminated with the following message:

> *"We are unable to locate the Provider Identification Number. We're sorry, we are unable to complete your call. Please review the procedures in your AEVS User Guide or AEVS section of your provider manual. If you have any questions concerning AEVS, please contact the POS Help Desk at 1-800-427-1295. Denti-Cal providers should call 1-800-423-0507. Thank you for calling the Automated Eligibility Verification System. Good-bye."*

Transaction Menu

If the PIN can be verified by AEVS, you will receive the following prompt:

> *"To perform an Eligibility Verification, press 1. To perform a Share of Cost transaction, press 2. To perform a Medi-Service transaction, press 3. To perform a State-Only Family Planning transaction, press 4. To end this call, press 5."*

Recipient ID Number

Press 1 to verify eligibility. You will then hear the following message:

> *"Please enter your recipient identification number, followed by a pound sign (#)."*

Enter the recipient's Medi-Cal identification number followed by the pound sign key (#). If there are any alpha characters in the number, press the star key (*) and number keys that correspond with the letter.

Recipient Birth Date

If the recipient ID number you enter is invalid, AEVS will prompt you to re-enter the number. If the recipient identifier is entered correctly, you will receive the following message:

> *"Please enter the two-digit month and four-digit year of the recipient's birth date. For example, enter a birth date of June 20th, 1972 as 062072."*

Verifying Newborn Infant Eligibility

If you are verifying eligibility for a newborn infant billing on the mother's ID number, enter the mother's date of birth.

Date of Service

If the recipient birth date you entered is invalid, AEVS will prompt you to re-enter the date. If the date is entered correctly, you will receive the following message:

> *"Please enter the date of service in the format of two digits for the month, two digits for the day and four digits for the year. For example, enter March 5, 1994 as 03051994."*

When a valid date is entered, AEVS will attempt to access the requested recipient's eligibility information. At this point, you should be prepared to record the information provided by AEVS.

If the recipient's eligibility cannot be verified, you will receive the following message:

> *"No recorded eligibility for (month) (year) for recipient (ID number) with a birth date of (month) (year)."*

If the recipient has a Share of Cost, you will hear the following message:

> *"This Medi-Cal recipient has a Share of Cost of _ _ _ _ dollars. To hear this information again, press 1. Otherwise, please press 2."*

If AEVS is successful in retrieving the recipient's eligibility information for the month that you requested, you will receive the following message that will verify the recipient's eligibility by giving you the first six letters of the last name and the first initial:

> *"Thank you.*
> *The first six letters of the recipient's name are _ _ _ _ _ _.*
> *The recipient's first initial is _.*
> *The county code is _ _.*
> *The aid code is _ _.*
> *The Eligibility Verification Confirmation number is (number)."*

After this message is spoken, please be prepared to record the recipient's eligibility information on the *AEVS Response Log*.

Eligibility Message Types

The following are examples of messages you may receive when AEVS provides you with the recipient eligibility information that you requested. A recipient may have more than one eligibility message spoken for each transaction. Be prepared to record the following information:

> *"Recipient Medi-Cal eligible."*
>
> *"Recipient is Medi-Cal eligible for dialysis and related services only, with _ _ percent obligation."*
>
> *"Recipient is restricted to medical services related to pregnancy and family planning."*
>
> *"The recipient has other health insurance coverage under code (OHC code) – (OHC name) – (carrier code). Scope of coverage is: (scope of coverage [COV] code[s])."*

If available, you may also hear up to three occurrences of the carrier code and policy number. For a list of AEVS carrier codes, refer to *AEVS Carrier Codes for Other Health Coverage* on the Internet at *www.medi-cal.ca.gov* (click the "Publications" link, the appropriate "Provider Manual" link and then the "Online-Only Sections" link on the Medi-Cal Web site) and to the *Other Health Coverage (OHC) Codes Chart* section in this manual.

Note: Providers may view and download the online *AEVS: Carrier Codes for Other Health Coverage* section in Microsoft Word format.

After all eligibility messages are spoken for this transaction, you will receive the following message:

> *"To hear this information again, press 1. Otherwise, press 2."*

If you press 2, you will return to the main menu and hear the following message:

> *"To perform an Eligibility Verification, press 1. To perform a Share of Cost transaction, press 2. To perform a Medi-Service transaction, press 3. To perform a State-Only Family Planning transaction, press 4. To end this call, press 5."*

SHARE OF COST CLEARANCE OR REVERSAL

Introduction

The following process is used to access the Medi-Cal eligibility verification system to complete a Share of Cost clearance or reversal transaction.

Provider Identification Number (PIN)

Using a touch-tone telephone, dial **1-800-456-AEVS (2387)**. AEVS will respond with the following message:

> *"Welcome to the Medi-Cal Automated Eligibility Verification System, also referred to as A-E-V-S. Please enter your Provider Identification Number followed by a pound sign (#)."*

Enter your Provider Identification Number (PIN). AEVS will respond with the following message:

> *"Please wait while the requested information is retrieved."*

If the PIN cannot be found on the Provider Master File, AEVS will prompt you to re-enter the correct PIN. If the PIN cannot be found after the second try, the call will be terminated with the following message:

> *"We are unable to locate the Provider Identification Number. We're sorry, we are unable to complete your call. Please review the procedures in your AEVS User Guide or AEVS section of your provider manual. If you have any questions concerning AEVS, please contact the POS Help Desk at 1-800-427-1295. Denti-Cal providers should call 1-800-423-0507. Thank you for calling the Automated Eligibility Verification System. Goodbye."*

Transaction Menu

If the PIN can be verified by AEVS, you will receive the following prompt:

> *"To perform an Eligibility Verification, press 1. To perform a Share of Cost transaction, press 2. To perform a Medi-Service transaction, press 3. To perform a State-Only Family Planning transaction, press 4. To end this call, press 5."*

Press 2 to clear a Share of Cost liability or reverse a previous clearance. You will then hear the following message:

> *"To perform an update, press 1. To perform a reversal, press 2."*

Recipient ID Number

If you wish to clear a Share of Cost liability, press 1. If you wish to reverse a previously cleared SOC liability, press 2. After you press 1 or 2, you will receive the following message:

> *"Please enter your recipient identification number, followed by a pound sign (#)."*

Enter the recipient's Medi-Cal identification number followed by the pound sign key (#). If there are any alpha characters in the number, press the star key (*) and number keys that correspond with the letter.

Recipient Birth Date

If the recipient ID number you enter is invalid, AEVS will prompt you to re-enter the number. If the recipient identifier is entered correctly, you will receive the following message:

> *"Please enter the two-digit month and four-digit year of the recipient's birth date. For example, enter a birth date of June 20th, 1972 as 062072."*

Verifying Newborn Infant SOC

If you are performing this transaction for services rendered to a newborn infant billing on the mother's ID number, enter the mother's date of birth.

Date of Service

If the recipient birth date you entered is invalid, AEVS will prompt you to re-enter the date. If the date is entered correctly, you will receive the following message:

> *"Please enter the date of service in the format of two digits for the month, two digits for the day, and four digits for the year. For example, enter March 5, 1994 as 03051994."*

If the date of service that you entered is invalid, AEVS will prompt you to re-enter the date.

Note: If you have to re-enter the date of service, this is considered to be an additional inquiry and will count against the 10 inquiries you are allowed per call.

Procedure Code

If the date is entered correctly, you will receive the following message:

"Please enter a valid procedure code followed by a pound sign (#)."

If the procedure code that you entered is invalid, AEVS will prompt you to re-enter the code. If the code is entered correctly, you will receive the following message:

> *"The procedure code entered was (procedure code). Is this entry correct? Enter 1 for yes or 2 for no."*

Total Billed Amount

If you press 1, you will hear the following message:

> *"Please enter the total billed amount in the format of dollars followed by an asterisk (*) and cents followed by a pound sign (#)."* (For example, for $20.50, enter "20*50#".)

If the amount you entered is invalid, AEVS will prompt you to re-enter the amount. If the amount is entered correctly, you will receive the following message:

> *"The billed amount entered was (amount). Is this entry correct? Enter 1 for yes or 2 for no."*

Case Number

If you press 1, you will hear the following message:

> *"Please enter the case number followed by a pound sign (#). Enter only the pound sign (#) if you wish to bypass the case number."*

Enter a pound sign (#) if the recipient does not have multiple Share of Cost cases. If the recipient has multiple cases, see "Multiple SOC Cases" on a following page.

Clearance With SOC Liability Remaining

After you press the pound sign (#) for a recipient without multiple cases, you will hear the following message if the recipient has additional liability:

> *"The amount deducted was (amount). The amount of Share of Cost remaining is (amount)."*

Clearance With No SOC Liability Remaining

After you press the pound sign (#) for a recipient without multiple cases, you will hear the following message if the recipient's Share of Cost is certified (no Share of Cost liability remaining):

> *"The first six letters of the recipient's name are _ _ _ _ _ _.*
> *The recipient's first initial is _.*
> *The county code is _ _.*
> *The aid code is _ _.*
> *The amount deducted was (amount). Share of Cost certified.*
> *The Eligibility Verification Confirmation number is (number)."*

You will then hear the messages telling you what kind of eligibility and/or restrictions the recipient has. For example:

> *"Recipient Medi-Cal eligible."*
>
> *"Recipient is Medi-Cal eligible for dialysis and related services only, with _ _ percent obligation."*
>
> *"Recipient is restricted to medical services related to mental health care."*

Multiple SOC Cases

If the recipient has multiple cases, enter the case number you wish to clear and press the pound sign (#). The recipient will have a letter listing all case numbers. If you do not enter a case number, and there is more than one case number associated with the recipient, you will hear the following message:

> *"Recipient is in multiple cases. The recipient has the following Share of Cost case numbers: Case number (#) currently has a Share of Cost amount of (amount). Case number (#) currently has a Share of Cost amount of (amount)."* (You will hear one to four case numbers associated with the recipient.) *"Please enter the case number followed by a pound sign (#)."*

If the recipient has more than four case numbers, you will also hear the following:

> *"The recipient also has additional Share of Cost case numbers not mentioned in this transaction."*

You can obtain a complete list of all the recipient's SOC case numbers from the recipient's *Share of Cost Case Summary* letter. Please see *Share of Cost (SOC*), in this manual.

Note: Each time you clear a Share of Cost for a case number counts as a transaction. You may clear up to 10 case numbers in one telephone call.

If you entered a case number, you will hear the following message after you press the pound sign (#):

> *"The case number entered was (case number). Is this entry correct? Enter 1 for yes or 2 for no."*

Entering Applied Amount For Case Numbers

If you press 1, you will hear the following message:

> *"Please enter the applied amount for the case number in the format of dollars followed by a star (*) and cents followed by a pound sign (#)."* (For example, for $10.25, enter "10*25#".)

If the amount you entered is invalid, AEVS will prompt you to re-enter the amount. If the amount is entered correctly, you will receive the following message:

> *"The applied amount entered was (amount). Is this entry correct? Enter 1 for yes or 2 for no."*

SOC Reversal

If you press 1, you will hear the following message <u>if you requested a Share of Cost reversal:</u>

> *"Amount added was (amount). Amount of Share of Cost remaining is (amount)."*

Requesting Reversal SOC Non-Phased-In Counties

If you request a Share of Cost clearance for a recipient whose county has not phased to plastic Benefits Identification Cards, you will hear the following message:

> *"The Share of Cost clearance system is not operative in the recipient's county for the month requested. Use the MC 177 form for Share of Cost clearance."*

Automated Eligibility Verification System (AEVS) Response Log

Transaction Type:

__ Eligibility Verification

__ Share of Cost (SOC)
__ spend down
__ reversal

__ Medi-Service
__ reservation
__ reversal

Information entered:

Recipient ID #: _____ Date of Birth: _____ (mm/yyyy) Date of Service: _____ (mm/yyyy)

Procedure Code: _____ (SOC or Medi-Service)

Billed Amount: $_____ (SOC only)

Applied Amount: $_____ (Multiple SOC Cases only) SOC Case #: _____
Applied Amount: $_____ (Multiple SOC Cases only) SOC Case #: _____
Applied Amount: $_____ (Multiple SOC Cases only) SOC Case #: _____

Response from the Network:

Recipient Name: _____ County Code: _____

Primary Aid Code: _____
1st Special Aid Code: _____
2nd Special Aid Code: _____

Message(s): _____

_____

_____

Share of Cost (if any): $_____

Case #: _____ SOC: $_____
Case #: _____ SOC: $_____
Case #: _____ SOC: $_____

Medicare Coverage: ___ Part A ___ Part B HIC #: _____

Other Health Insurance Coverage code: _____

Scope of Coverage (circle those which apply): *V P L O I M COMPREHENSIVE*

Eligibility Verification Confirmation Number: _____

Today's Date: _____ Transaction performed by: _____

(THIS FORM IS FOR YOUR RECORDS ONLY)