STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814
(916) 445-1912

August 26, 1983

To: All County Welfare Directors Letter No. 83- 56

ELIGIBILITY DOCUMENTATION FOR THE APPEAL OF DENIED PROVIDER CLAIMS

The Department of Health Services (DHS) is experiencing an increase in the number of denied claims that are being appealed through the Provider Relations Section. This letter is to inform county welfare departments of the documentation that DHS will accept for verifying Medi-Cal eligibility for the second level appeal of denied Medi-Cal provider claims. This information is being provided so that counties can assist Medi-Cal providers in obtaining reimbursement for Medi-Cal services rendered to eligible Medi-Cal beneficiaries.

The acceptable documentation will differ depending on the type of Medi-Cal card issued and the Medi-Cal processing system used by the county. For MEDS counties, a copy of the MEDS Full Status Inquiry screen will be accepted by the Provider Relations Section as documentation of Medi-Cal eligibility. For non-MEDS counties, a copy of the DHS Medi-Cal ID Card Register List (Share of Cost and non-Share of Cost Register Lists) will be accepted as documentation of eligibility. If a claim was denied for an SSI/SSP Medi-Cal beneficiary, a copy of the county SDX report will be accepted as documentation of eligibility. If a claim was denied for a beneficiary who was issued an immediate need Medi-Cal card via the Temps and Returns System (TARS), A copy of the TARS input document (HAS 2007) will be accepted as eligibility documentation DHS is in the process of developing a report that will list all the accepted records in the TARS. When the report is developed and distributed to the counties, it can replace the HAS 2007 as documentation of Medi-Cal eligibility.

The county health facility Medi-Cal providers who are experiencing problems with denied claims for apparently eligible Medi-Cal beneficiaries, should request a denial reconsideration-claim inquiry (within 60 days of the date of denial) or request a first level appeal through the fiscal intermediary (within 90 days of the date of denial). If the providers are not satified with the results of the first level appeal, they should submit the claim document, the fiscal intermediary's remittance advice, and the Medi-Cal eligibility documentation (within 90 days of the date of the first level appeal denial) to the Provider Relations Section, 714 P Street, Room 950, Sacramento, CA 95814.

If you have any questions or problems regarding this procedure, please contact the Provider Relations Section at (916) 322-8451.

Sincerely,

ORIGINAL SIGNED BY

Caroline Cabias, Chief
Eligibility Branch

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants