Drug/Medi-Cal Claims Standard Process

Billing Drug Medi-Cal is a process with Providers, County and state staff all playing a role. Below is an outline of the typical submission and adjudication processes for Medi-Cal claims.

Step 1: Verifying Eligibility: Clients will present the provider with a Drug/Medi-Cal card. It is up to the provider to verify the information. There are several ways to verify eligibility; two possible sites for verification are the State Medi-Cal or Partnership Health websites. Please review common eligibility codes.

Step 2: Sign client up for WITS and electronic billing.

Step 3: Billing deadlines: The County requires that claims and the DHCS DMC Claim Certification Form are submitted by the 10th of the month following the date of service so that the county can meet the state deadline of the 30th day in the month following the date of service. Late claims (except for those situations defined in the Good Cause Certification form 6065) will not be processed.

Step 4: Provider batches and sends claims to the clearinghouse (County is clearinghouse)

Step 5: Utilization review with County staff and eligibility checks by agency staff must be completed on a monthly basis prior to submission to the county.

Step 6: County uploads provider batches to ITWS (the state).

Step 7: State system provides automatic checks on file. If file passes it is forwarded to state staff for adjudication. If it fails the county will notify the provider via email and reject the file in WITS for trouble shooting. Failed files are not considered denied but rather not submitted. Files must be corrected and submitted before the 30th day of the month following services. Providers must communicate with County staff to assure that someone can be available to upload the file within the allotted time frame (prior to 30th day of month following date of service).

Step 8: Files that are accepted by ITWS go through another computer generated electronic review where most denials are caught including but not limited to clients with other health coverage that should have been billed first, lack of proof of eligibility, incorrect NPI numbers, incorrect service codes, and duration errors. The state posts these denials within a few days of the original upload. Approvals take longer to review and are supposed to be posted to ITWS within a few weeks of submission.

Step 9: County downloads denials or approvals from ITWS and uploads them into the WITS system.

Step 10: The WITS system generates an EOB within 24 hours.

Step 11: County staff alerts provider of payment # which can be used to check approvals and denials within WITS. The county is not responsible for tracking claims that need to be corrected or resubmitted.

Step 12: Provider reviews EOB's based on payment #.

Step 13: If payment # is for denials provider ascertains whether claims can be corrected and rebilled.

Step 14: If claims can be corrected or rebilled, provider makes corrections and resubmits to the clearinghouse. Provider also emails county staff to alert them of the corrected files. Good cause paperwork (for late submissions and resubmissions) must be sent to the county by fax or encrypted email before county can upload file to ITWS. Denials must be resubmitted within 6 months. Providers are responsible for tracking claims that must be resubmitted and ensuring that claims are submitted within allowable time frames.