TITLE 22
Section 51502.1 Requirements for Electronic Claims Submission

(a) As used in this section, the following definitions shall apply:

(1) "Biller" includes any employee, officer, agent or director of the entity which will bill on behalf of a provider pursuant to a contractual relationship with the provider which does not include payment to billers on the basis of a percentage of amount billed or collected from Medi-Cal.

(2) "Source Documents" include every document or record on which the provider or the biller relies to submit a claim, as described in Title 22, Section 51476. Source documents shall also include all printed representations of information transmitted as a claim to the biller or the fiscal intermediary, whether transmitted by the provider or biller.

(3) Provider" shall have the same meaning as in Section 51051 of these regulations.

(4) "Electronic claims submission" means that submission of Medi-Cal claims for service on magnetic tape, computer-to-computer via telephone or other electronic means which are approved by the Director as being compatible with and acceptable for processing by the State claims processing system.

(b) Any enrolled provider may request of the Department authorization to transmit claims to the fiscal intermediary electronically. The Director shall provide written acknowledgement of provider's request for electronic claims submission participation within 30 days of receipt of the request. This acknowledgement shall identify additional information, if any, needed. The Director shall notify the provider in writing of approval or denial within six months of receipt of the request. In the event that the request is denied, the written notice shall specifically set forth the reasons for the denial.

(c) The Director shall authorize such billing unless the Director determines that the requesting provider is ineligible for electronic claims submission. In determining eligibility, the Director shall consider the provider's history of Medi-Cal provider participation, for the three years preceding provider request for participation. A provider shall be determined ineligible for electronic claims submission if during the three years one of the following criteria is met. The provider has:

(1) Been convicted of any felony, crime or misdemeanor involving fraud or abuse of the Medi-Cal, Medicaid or Medicare programs.

(2) Been convicted of any crime involving dishonesty, corruption, theft, fraud, kickbacks, rebates or bribes.

(3) Been found liable or convicted in any civil or criminal legal action involving misuse of electronic communication mechanisms.

(4) Been the subject of any civil or criminal proceedings by any private or public entity administering Medi-Cal, Medicaid or private insurance, which result in one of the following: suspension from the Medi-Cal program in accordance with Title 22, CAC, Section 51458, placement on special claims review in accordance with Section 51460, placement on prior authorization in accordance with Title 22, CAC, Section 51455, recovery of overpayments in excess of 10 percent of total provider annual Medi-Cal payments for the most recent full fiscal year in accordance with Title 22, CAC, Section 51458.1 or the filing of criminal charges for fraudulent billing of the Medi-Cal program in accordance with Sections 14107 of the Welfare and Institutions Code and 72 of the Penal Code.

(5) Failed or refused to provide the Department, its duly authorized agents or agents of other state or federal agencies charged with the review of state or federal expenditures with patient records, source documents or other documentation required by statute or regulation.

(6) Made any false or misleading statement in patient records, substantiation of claims, requests for prior authorization, Departmental application or other documentation in violation of statute or regulation.

(d) Any provider determined by the Director to be eligible for electronic claims submission may employ a biller certified by the Director as eligible to perform such billing. The Director shall provide written acknowledgement of biller request to perform such billing for an eligible provider within 30 days of application date. This acknowledgement shall identify additional information, if any, needed. The Director shall notify biller in writing of approval or denial within six months of request receipt. In the event such a request is denied the written notice shall specify reasons for denial. In determining the eligibility of a biller, the Director shall consider the biller's history of Medi-Cal participation or overall business activities for the three years preceding participation request receipt. A biller shall be determined to be ineligible for electronic claims submission if one of the following criteria is met during the three years preceding receipt of request for participation. The biller has:

(1) Been convicted of any crime involving dishonesty, corruption, fraud, computer fraud, embezzlement, larceny, forgery, falsification of documents, kickbacks, rebates or bribes.

(2) Been found liable or convicted in any civil, criminal or administrative actions involving illegal use of electronic communication mechanisms.

(3) Submitted claims for services not claimed by a provider or for a greater dollar amount than claimed by a provider under the Medi-Cal, Medicaid, Medicare programs or any other health insurance carrier.

(4) Entered an agreement for compensation with any provider based upon percentage or other variable related to the amount billed or collected from the Medi-Cal, Medicaid, or Medicare programs in violation of state or federal law.

(5) Failed or refused to produce source documents for the Department, its duly authorized agents or agents of other state or federal agencies charged with review of state or federal expenditures as provided in statute or regulation.

(6) Failed to demonstrate it employs adequate precautions to protect the confidentiality of Medi-Cal beneficiary records and claims submission methods in accordance with statue or regulation.

(e) The agreement between a provider and a biller shall be in writing and shall be readily retrievable and available on request to the Department or any duly authorized agency for Departmental review to ensure compliance with state and federal standards. Said agreement must in no case contain an agreement for compensation of the biller based on a formula which has as a factor the percentage of the amount billed or collected from the Medi-Cal, Medicaid or Medicare programs in violation of state or federal law.

(f) Any provider or biller eligible for electronic claims submission shall, prior to engaging in any such billing, enter into an agreement with the Department specifying the conditions of participation in such billing methods. This agreement shall be drafted by the Department. The provider and biller shall agree to conditions which shall include, but not be limited to, the following:

(1) Any and all source documents used in documenting, preparing or submitting claims shall be retained in a manner readily retrievable and shall be made available to agents of the Department or any other duly authorized agency on request during normal business hours. Out-of-state providers may be required to produce source documents at a location designated by the Department within the State of California.

(2) All source documents shall be maintained for a period of at least three years from the date received by the FI for payment, as specified by Title 22, CAC, Section 51476.

(3) Source documents, originals or on microfilm/microfiche, shall show the identification of the person or persons who actually rendered the service claimed. All providers shall have on file a printed representation of all information transmitted electronically as a claim by the provider to the biller or the fiscal intermediary. All billers shall produce a printed representation of all information transmitted electronically as a claim by the provider to the biller on demand of the Department or any other authorized agency.

(4) Any instructions between a provider and a biller related to the submission of Medi-Cal claims shall be in writing and available for inspection.

(5) Claims shall not be processed until such time as the Department's fiscal intermediary receives, verifies and posts a Claims Certification Statement and Control Sheet, which shall include all of the following:

(A) A certification of the truth and accuracy of each claim.

(B) The number and total dollar amount of claims submitted.

(C) Such beneficiary identification as the Department may require.

(D) The signature of the provider or the provider's agent.

(6) The Department shall be promptly notified by the provider of any changes in a provider's or biller's status which might affect such person's ability to participate in electronic billing methods.

(7) The provider shall be responsible for ensuring that all remittances and paid claims information are reviewed and that corrections for any overpayments are promptly pursued through the Department's Fiscal Intermediary within the applicable limits of Section 51008(d) of Title 22, CAC.

(8) The provider shall bill those services requiring submission of a MEDI label or other attachment with the claim in accordance with Department billing instructions including instructions regarding structuring the remarks section in a format compatible with electronic data submission.

(g) No provider or potential biller shall submit claims electronically without first securing the approval of the Department for the system to be used for claims submission. In reviewing a proposed billing system, the Department may request submission of a test billing and consider the:

(1) Compatibility with and acceptability for processing by the State claims processing system.

(2) Provider's or potential biller's system for maintaining adequate documentation to support the services, claims and medical necessity thereof.

(h) The test billing and signed provider/biller agreements shall constitute formal request for participation in the electronic claims submission program.

(i) Ongoing approval of the billing system is contingent upon maintenance of the system as approved by the Department under subsection (g). Failure to do so shall be considered grounds for the Department to disapprove the provider or biller for the submission of claims electronically.

(j) Failure or refusal of a provider or a biller to continue to comply with the standards of participation set forth in subsections (c) through (g) shall subject a provider or biller to immediate suspension from participation in the electronic claims submission program. For purposes of applying the standards set forth in those subsections (c) and (d), suspension will occur if one of the events set forth in those subsections has occurred during the three year period prior to the proposed suspension. Notification of the suspension shall be in writing. The provider or biller has the right to appeal the suspension in writing within 30 days of the date of notification. The Department shall review the appeal and any supporting documents in accordance with the time frames and procedures specified in Section 51015(d) of these regulations.

NOTE:Authority cited: Sections 10725, 14040, 14105 and 14124.5, Welfare and Institutions Code; and Section 78, Chapter 146, Statutes of 1999. Reference: Sections 14040, 14100.2, 14107, 14115, 14124.1, 14124.2 and 14170, Welfare and Institutions Code.

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