Substance Use Disorder Information System

Communication Release

06/28/2021

SAPC Verification of Medi-Cal Eligibility

Due to the large number of State denials across the network, SAPC has been investigating causes and solutions to assist providers in preventing State denials. SAPC has identified client Medi-Cal eligibility as one of the largest preventable denials. These denials are seen under the various CARC/RARC combinations of CO 177. In an effort to minimize these denials, **effective 07/01/2021**, SAPC will implement a two-step process that will verify Medi-Cal Eligibility at the authorization level and the claim level. These two new processes will give providers immediate denial information that can be used to better manage their given programs. Traditionally, providers may wait weeks to months before knowing if a claim was denied by the State due to Medi-Cal eligibility.

Authorization Level Verification: Starting 7/1/2021, all newly submitted DMC authorizations will be verified against the current Medi-Cal Eligibility Data Set (MEDS), which contains eligibility on file at DHCS. For those patients submitted as DMC eligible by providers, QI & UM Care Managers will be checking for valid aid codes, county codes, and eligibility status based on similar information given to providers through the AEVS, Real-Time 270 Eligibility Request, and Medi-Cal eligibility portal. If there is a discrepancy in what the provider submitted and what the MEDS file shows, providers will be given the opportunity to resolve the issue before the authorization is denied.

Providers should take the following steps to resolve situations in which the patient is showing as ineligible on the current MEDS file:

1. Ensure the CIN listed on the DMC guarantor is the correct CIN for that patient.
2. Run the Real-Time 270 Eligibility Request in Sage for the date of authorization.
3. Upload the printout from Medi-Cal system that was used to verify eligibility via the Attachments in Sage.
4. If patient is deemed ineligible for DMC, but is enrolled in another county funding program, correct the Financial Eligibility and submit a new authorization under Non-DMC and request to deny the DMC authorization.

Additionally, authorization dates may be modified based on the eligibility dates within the MEDS file. If the patient is eligible for other county funding, Applying for Medi-Cal coverage, or later gets retroactive Medi-Cal, providers may be able to submit for the remainder of the authorization dates.

Claim Level Verification: In addition to authorization level checks, SAPC will implement a system level verification when claims are submitted for local adjudication. For DMC claims submitted via Sage and 837 files, the system will cross check the patient eligibility against the current MEDS file. If the patient has a valid aid code and no other restrictions, such as Share of Cost/Spenddown, the claim will be adjudicated as normal. However, if the aid code is not a valid DMC aid code or the patient has other restrictions that make the patient ineligible for the dates of service being claimed, the claim will be denied for the following Claim Status Denial Reason: "This client is not eligible for this service. Avatar Financial Eligibility Record check failed. Changing claim status to Denied and the reason to Eligibility not found/verified in CalPM." This is the message that will appear on the Pre-Adjudication screen in Sage for Primary Sage Users and the EOB Remittance Advice, as well as the Claim Denial View in MSO KPI. This denial reason will correspond with the CARC/RARC combination of CO 177 N59 on the subsequent 835 file.

When this denial occurs, providers should take the following resolution steps to validate if the claim can be resubmitted:

1. Ensure the CIN listed on the DMC guarantor is the correct CIN for that patient.
2. Run the Real-Time 270 Eligibility Request in Sage to ensure the MEDS file has the most updated information.
    a. If the patient has a Share of Cost, the MEDS file will show the patient as ineligible at the beginning of the month. When the Share of Cost/Spenddown amount has been reached, the only way to update that information on the MEDS file for the given month is running the 270 Eligibility Request in Sage. Otherwise the information for the current month will not be updated until the following month's MEDS file is loaded.
3. Check the AEVS, Medi-Cal eligibility website, or POS machine to verify current eligibility status for the date of service.

    a. If eligibility from DMC shows eligible, contact the agency's Finance Analyst at SAPC to confirm MEDS file information before resubmitting the claim.
4. If the issue is related to a delay in the Medi-Cal system updating current status, providers should wait until the following month for the next MEDS file to update the patient's status and run the 270 Eligibility Request for the dates of service that were denied.

With these processes in place, providers will have much higher confidence that the claims will not be denied by the State. However, all SAPC approved claims are still subject to State denials for several other reasons outside of SAPC's control. While these processes should limit the risk of a State denial, they will not eliminate that risk completely. To further minimize the risk, providers must check eligibility with the State systems at admission and every subsequent month during treatment, including verifying the aid code is eligible for DMC benefits and the patient's Medi-Cal is assigned to LA County. Additionally, providers should ensure patient information is correct in Sage and matches the provider's EHR, if applicable.
