BOARD OF TRUSTEES
Agenda Item Description

BOARD MEETING DATE: 3/10/2016

SUBJECT: Approval of three-party agreement with California Department of Health Care Services, Medical Billing Technologies and NVC Student Health Services re Medi-Cal Electronic Billing Agreements.

PROPOSAL: The Student Health Services has recently been approved by the California Department of Health Care Services as a Medi-Cal and Family PACT provider. Family PACT is a Medi-Cal program, which pays for family-planning related services for low-income people who lack access to health insurance. The attached documents are routine agreements required to be signed by all Medi-Cal providers. They allow us to access the Medi-Cal online insurance enrollment, verification, and billing systems. The agreements also inform Dept of Health Care Services of our intention to employ the firm "Medical Billing Technologies" as our billing agent. The term of the agreement is perennial until we cancel.

RECOMMENDATION: Approve the agreements with California Department of Health Care Services, Medical Billing Technologies and NVC Student Health Services.

SUPPORTING INFORMATION:

Background & Summary: .There is no charge for access to these systems. We are proposing to use a 3rd party billing agent, Medical Billing Technologies. The Electronic Billing Agreements allow us to designate Medical Billing Technologies as our agent for this purpose. This has also been reviewed by NVC Risk Management.

Fiscal Impact of Proposal: Minimal staff time to prepare and submit documentation. This agreement will allow NVC, specifically the Health Services Center, to bill for Medi-Cal services, with an estimated income to the college in the range of $15,000 annually.

SUMMARY (contracts, MOU's, agreements only):

Item #	NAME/ Contracting Party	TYPE & TERM	DESCRIPTION	FISCAL IMPACT TO DISTRICT	SUBMIT-TED BY:
Pres. Office use only	Calif. Dept of Health Care Services; Medical Billing Technologies, Inc.	On-going. Can be terminated with 30-day notice.		Positive. Income of approx. $15,0000	De Haro/ Tamarisk

Submitted By:

Nancy Tamarisk
Interim Director, Student Health Services

Approved for Consideration By:

Oscar De Haro
Vice-President, Student Services

Attachments? Yes ☒ No ☐

MEDI-CAL TELECOMMUNICATIONS PROVIDER AND BILLER APPLICATION/AGREEMENT

(For electronic claim submission)

1.0 IDENTIFICATION OF PARTIES

This agreement is between the State of California, Department of Health Care Services, hereinafter referred to as the "Department," and:

PROVIDER INFORMATION

Field	Value
Provider name (full legal)	Napa Valley Community College District
Provider number	1538562996
DBA (if applicable)	
Last 4 digits of Tax Id Number or Social Security Number:	4463
Provider service address (number, street)	2277 Napa-Vallejo Highway
City	Napa
State	CA
ZIP code	94558-6236
Contact person	Nancy Tamarisk
E-mail address	ntamarisk@napavalley.edu
Contact person address (number, street)	
City	
State	
ZIP code	
Contact telephone number	(707) 256-7780
Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)	

BILLER INFORMATION (If other than the provider of service)

Field	Value
Biller name (full legal)	Medical Billing Technologies, Inc
Biller telephone number	(559) 627-6267 ext. 210
DBA (if applicable)	
E-mail address	tward@mbt4schools.com
Business address (number, street)	525 W. Main St., Suite F
City	Visalia
State	CA
Zip code	93291
Contact person	Tiffany Ward
Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)	7L0

Full legal name(s) required as well as any assumed (DBA) name(s), address(es), and Medi-Cal provider number(s). The parties identified above will be hereinafter referred to as the "Provider" and/or "Biller."

1.1 CMC Batch Submission Type:

- ☒ Dial-up
- ☐ Magnetic tape
- ☒ Internet*

Real Time Submission Type:

- ☐ Point of Service (POS)
- ☐ Internet*
- ☐ Leased Line *or* ☐ Dial-up

* Note: Requires a completed network agreement on file.

INDICATE CLAIM TYPES WHICH WILL BE SUBMITTED ELECTRONICALLY

NCPDP Version (indicate version): ______________

- ☐ Pharmacy (01)

ANSI X 12 837 Version (indicate version): 5010

- ☐ Long-Term Care (02)
- ☐ Inpatient (03)
- ☒ Outpatient (04)
- ☐ Medical/Allied Health (05)
- ☐ Vision (05)
- ☐ CHDP (11)
- ☐ Medicare Crossover Part A
- ☐ Medicare Crossover Part B

ANSI X 12 276/277 Version (indicate version): ______________

- ☐ Claim Status Inquiry/Response

ANSI X 12 278 Version (indicate version): ______________

- ☐ Health Care Services and Review

1.2 BACKGROUND INFORMATION

The Provider/Biller agrees to provide the Department with the above information requested in order to verify qualifications to act as a Medi-Cal electronic Biller.

2.0 DEFINITIONS

The terms used in this agreement shall have their ordinary meaning, except those terms defined in regulations, Title 22, California Code of Regulations, Section 51502.1, shall have the meaning ascribed to them by that regulation as from time to time amended. The term "electronic" or "electronically," when used to describe a form of claims submission, shall mean any claim submitted through any electronic means such as: magnetic tape or modem communications.

3.0 CLAIMS ACCEPTANCE AND PROCESSING

The Department agrees to accept from the enrolled Provider/Biller, electronic claims submitted to the Medi-Cal fiscal intermediary in accordance with the Medi-Cal provider manuals. The Provider hereby acknowledges that he has received, read, and understands the provider manual and its contents, and agrees to read and comply with all provider manual updates and provider bulletins relating to electronic billing.

3.1 CLAIMS CERTIFICATION

The Provider agrees and shall certify under penalty of perjury that all claims for services submitted electronically have been personally provided to the patient by the Provider or under his direction by another person eligible under the Medi-Cal Program to provide to such services, and such person(s) are designated on the claim. The services were, to the best of the Provider's knowledge, medically indicated and necessary to the health of the patient. The Provider shall also certify that all information submitted electronically is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider/Biller agrees to keep for a minimum period of three years from the date of service an electronic archive of all records necessary to fully disclose the extent of services furnished to the patient. A printed representation of those records shall be produced upon request of the Department during that period of time. The Provider/Biller agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California to the California Department of HealthCare Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services; or their duly authorized representatives. The Provider also agrees that medical care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability. The Provider/Biller agrees that using his Medi-Cal Submitter ID plus DHCS-issued password when submitting an electronic claim will identify the submitter and shall serve as acceptance to the terms and conditions of the Department's Telecommunications Provider and Biller Application/Agreement (DHCS 6153), paragraph 3.0. The Provider/Biller further acknowledges the necessity of maintaining the privacy of the DHCS-issued password and agrees to bear full responsibility for use or misuse of the Medi-Cal Submitter ID and password should privacy not be maintained.

3.2 VERIFICATION OF CLAIMS WITH SOURCE DOCUMENTS

Regardless of whether the Provider employs a Biller, the Provider agrees to retain personal responsibility for the development, transcription, data entry, and transmittal of all claim information for payment. This includes usual and customary charges for services rendered. The Provider shall also assume personal responsibility for verification of submitted claims with source documents. The Provider/Biller agrees that no claim shall be submitted until the required source documentation is completed and made readily retrievable in accordance with Medi-Cal statutes and regulations. Failure to make, maintain, or produce source documents shall be cause for immediate suspension of electronic billing privileges.

3.3 ACCURACY AND CORRECTION OF CLAIMS OR PAYMENTS

The Provider agrees to be responsible for the review and verification of the accuracy of claims payment information promptly upon the receipt of any payment. The Provider agrees to seek correction of any claim errors through the appropriate processes as designated by the Department or its fiscal intermediary including, but not limited to, the process set out in Title 22, California Code of Regulations, Section 51015 and, as from time to time amended. The Provider/Biller acknowledges that anyone who misrepresents or falsifies or causes to be misrepresented (or falsified) any records or other information relating to that claim may be subject to legal action, including, but not limited to, criminal prosecution, action for civil money penalties, administrative action to recover the funds, and decertification of the Provider/Biller from participation in the Medi-Cal program and/or electronic billing.

4.0 CHANGE IN ELECTRONIC BILLING STATUS

The Provider/Biller and the Department agree that any changes in Provider/Biller status which might affect eligibility to participate in electronic billing pursuant to federal and state law shall be promptly communicated to each party.

5.0 PROVIDER/BILLER REVIEWS

The Provider/Biller agrees that agents of the Department of Health Care Services, the Office of the State Controller, the Department of Justice, or any other authorized agent or representative of the State of California or any authorized representative of the U.S. Department of Health and Human Services may, from time to time, conduct such reviews as are necessary to ensure compliance with state and federal law and with this agreement. In particular, the Provider/Biller agrees to make available to such agent or representative all source documents necessary to verify the accuracy and completeness of claims submitted electronically.

5.1 NONEXCLUSIVE REVIEWS

The Provider/Biller agrees that the review set out in paragraph 5.0 above is not exclusive but supplements any other form of audit or review the Provider/Biller may be subject to due to its status as a certified Provider/Biller of services under the Medi-Cal or Medicare programs.

6.0 EFFECTIVE DATE

This agreement shall become effective upon approval of the Department.

6.1 TERMINATION

The Department or Provider may terminate this agreement with or without cause by giving 30 days prior written notice of intent to terminate, and the Provider has no right to appeal such termination by the Department. The Department may, however, terminate this agreement immediately, pursuant to paragraph 6.2 upon determination that the Provider/Biller has failed or refused to produce or retain source documents in accordance with federal and state law or this agreement.

6.2 TERMINATION FOR CAUSE

If the Provider/Biller is unable to produce source documents on request pursuant to paragraph 5.0, the Department may terminate this agreement immediately by directing its fiscal intermediary to cease payment of any and all electronic claims submitted by the Provider/Biller, including any claims in process on the date of such termination. The Provider/Biller has no right to appeal termination for cause pursuant to this subpart prior to the effective date of such termination. The Provider/Biller may appeal any grievance resulting from the termination in accordance with the procedure established by Title 22, California Code of Regulations, Section 51015, as from time to time amended. The Department may demand repayment of claims for which no source documents are produced, and the Provider/Biller shall have a right to appeal of such an overpayment finding to the extent provided by Section 14171 of the Welfare and Institutions Code and regulations promulgated pursuant thereto, and as from time to time amended.

6.3 EFFECT OF TERMINATION AND APPEAL

On termination pursuant to paragraph 6.1 or 6.2, the Provider/Biller may submit hard copy claims.

7.0 AGREEMENT BETWEEN PROVIDER AND BILLER (IF OTHER THAN THE PROVIDER OF SERVICE)

The Provider stipulates that any agreements with Billers to submit Medi-Cal electronic billings shall be in conformance with state law governing electronic claims submission, and shall contain provisions including, but not limited to, the following:

a. The Provider shall specifically designate the Biller as the agent to the Provider for the purpose of preparation and submission of Medi-Cal claims by the Biller. As the Provider's agent, the Biller agrees to comply with all Medi-Cal requirements on recordmaking and retention as established by statute and regulation including, but not limited to, Welfare and Institutions Code, Sections 14124.1 and 14124 and Title 22, California Code of Regulations, Section 51476.

b. Electronic billing for services rendered to Medi-Cal beneficiaries shall be prepared by the Biller solely from information supplied by the Provider. This information includes usual and customary charges for services rendered. A printed representation of source documents as defined in Title 22, California Code of Regulations, Section 51502.1 shall be kept, including all information transmitted as a claim by the Provider to the Biller electronically, or a period of at least three years from the date of claims submission.

c. If a department audit is initiated, the Billing Service shall retain all original records described in paragraphs 3.2, 5.0, and 7.0(b) above until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond three years from the date of the service of termination of financial relationship or longer period required by federal or state law.

d. The parties shall agree that the Department may accept electronic billings prepared, certified, and submitted by the Biller on behalf of the Provider only as long as the agreement between the Provider and the Biller remains in existence and in effect.

e. Both parties have a duty to notify the Department in writing immediately upon any change in or termination of their agreement.

8.0 DECLARATION OF INTENT

This agreement is not intended as a limitation on the duties of the parties under the Medi-Cal Act, but rather as a means of clarifying those duties as they relate to the Provider/Biller in its capacity as an authorized Provider/Biller for electronic billing.

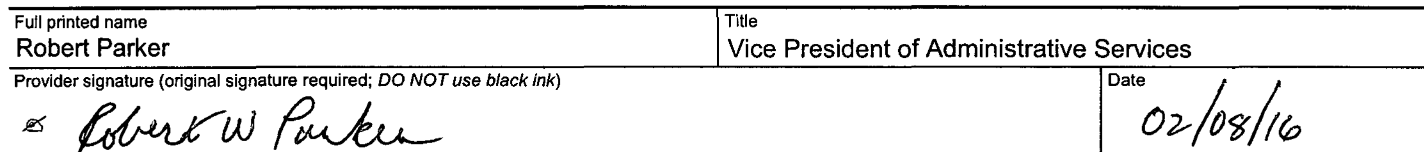
8.1 PROVIDER TO HOLD STATE OF CALIFORNIA HARMLESS

The Provider agrees to hold the State of California harmless for any and all failures to perform by billing services, billing software, or other features of electronic billing which do not occur with (hard copy) paper billing. The Provider explicitly agrees that the Provider is assuming any and all risks that accompany electronic billing and that the Provider is not relying upon the evaluation, if any, that the State has made of the electronic billing system, software, or Biller the Provider is using. Furthermore, the Provider acknowledges that if the electronic billing system, software, or Biller contracted with, is or has been listed as available in Medi-Cal bulletins, that such listing was not an endorsement by the State of California nor does it imply that the service, system, or software has met or is continuing to meet a standard of performance.

9.0 CONFIDENTIALITY OF RECORD

The Provider/Biller agrees to provide adequate precautions to protect the confidentiality of Medi-Cal beneficiary record and claims submission methods in accordance with statute or regulations Title 17, CCR, Section 6800, et seq. and/or 42 CFR, Part 400 and 440, Subpart B.

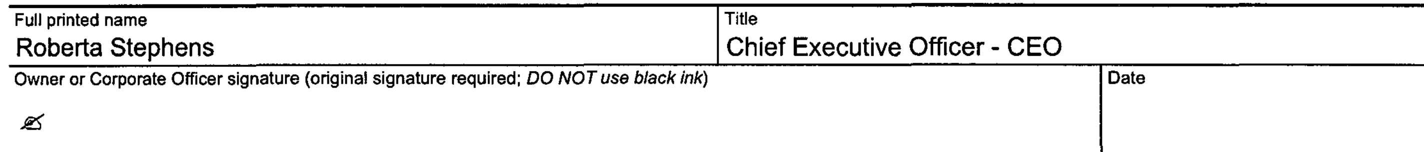
PROVIDER SIGNATURE INFORMATION



Full printed name	Title
Robert Parker	Vice President of Administrative Services

Provider signature (original signature required; *DO NOT use black ink*)	Date
Robert W Parker	02/08/16

BILLING SERVICE SIGNATURE INFORMATION (complete only if "Biller Information" is completed on page 1 of 4)



Full printed name	Title
Roberta Stephens	Chief Executive Officer - CEO

Owner or Corporate Officer signature (original signature required; *DO NOT use black ink*)	Date

Return Application/Agreement to: Xerox State Healthcare Services, LLC.
CMC Unit
P.O. Box 15508
Sacramento, CA 95852-1508

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

MEDI-CAL POINT OF SERVICE (POS) NETWORK/INTERNET AGREEMENT

This agreement is required for all providers and non-providers (provider representatives) who intend to use the Medi-Cal POS Network or Medi-Cal website applications at www.medi-cal.ca.gov.

I.

(a). The following is required only for enrolled Medi-Cal providers: The Department of Health Care Services (DHCS) will permit the use of the California POS Network and Medi-Cal website by the following Medi-Cal provider subject to the terms and conditions of this agreement.

Provider Name: Napa Valley Community College District
Provider Number/NPI: 1538562996
Owner Number: ______________________ (If applicable)
Tax ID: 68-0314463

(b). The following is required only if intending to use a device and/or software that is not obtained through Medi-Cal:

Vendor/Developer Company Name: ______________________

CMC Submitter Number (if applicable): ___ ___ ___

Contact Person: ______________________

Phone Number: (___ ___ ___) ___ ___ ___ ___ ___ ___ ___

(c). The following is required only for non-provider users [provider representatives] of the POS Network/Medi-Cal website: DHCS will permit the use of the Medi-Cal POS Network and/or Medi-Cal website by the authorized provider representative ______________________ (Representative) subject to the terms of this agreement. When applicable, please attach to this agreement a list of all provider numbers/NPIs and corresponding Tax Identification Numbers (TINs) for which the non-provider user is also the authorized representative.

(d). Provider/Representative is requesting to delete access and usage of the POS Network and/or Medi-Cal website to the following provider representative ______________________ (Representative) subject to the terms of this agreement. When applicable, please attach to this agreement a list of all provider numbers/NPIs and corresponding TINs for deletion.

II. Provider/Representative agrees to limit the usage of the POS Network and Medi-Cal website to the following Medi-Cal eligibility and claims-related transactions:

A. Verification of Medi-Cal eligibility
B. Share of Cost (Spend Down) clearance
C. Medi-Service reservations
D. Submission of Pharmacy claims (may only be performed by providers enrolled to submit claims on the *Pharmacy/Medical Supplies Claim Form*): applies to Medi-Cal website only
E. Submission of ANSI ASC X12N 837 professional claims (may only be performed by providers enrolled to submit claims on the Medi-Cal Medical Services claim form): applies to Medi-Cal website only
F. Submission of electronic Treatment Authorization Requests (i.e. eTAR and Pharmacy NCPDP)
G. Submission of other transactions as may be subsequently permitted by DHCS and as documented in one or more of the user manuals in the Publications area of the Medi-Cal website
H. Browsing of Medi-Cal website

Provider/Representative acknowledges that failure to limit the usage of the POS Network and/or Medi-Cal website to the transactions described above may, at a minimum, result in DHCS revoking the privilege to use the POS Network and/or Medi-Cal website. Provider/Representative acknowledges abuse of transactions available on the Medi-Cal website may result in DHCS revoking provider access to Medi-Cal website.

III. The Provider/Representative agrees that the following constitutes the only authorized methods of accessing the POS Network:

A. Medi-Cal-provided toll-free (800) line or 916-prefix phone line as documented in the *POS Device User Guide*
B. Provider- or Representative-provided leased phone lines

IV. Any computer accessing the Medi-Cal website is required to abide by all applicable State and Federal laws enacted today or in the future.

V. The Provider/Representative agrees to the following security requirements. All computers that access Medi-Cal data must meet the following requirements, in addition to any State and Federal required administrative, technical, physical, and organizational safeguards:

A. Antivirus software. All workstations, laptops and other systems that access the Medi-Cal website or process and/or store Medi-Cal Protected Health Information (PHI) must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.
B. Patch Management. All workstations, laptops and other systems that access the Medi-Cal Web site or process and/or store Medi-Cal PHI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process, which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.
C. System Timeout. The systems that access the Medi-Cal website or process and/or store Medi-Cal PHI must provide an automatic timeout, requiring re-authentication of the user session. It is recommended that the automatic timeout be after no more than 20 minutes of inactivity.
D. User Name and Password Controls. Systems that access the Medi-Cal website or process and/or store Medi-Cal PHI should be accessed using a unique user name. The user name must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password. Passwords are not to be shared. Passwords must be: (1) At least eight characters, (2) A non-dictionary word, (3) Not be stored in readable format on the computer, (4) Be changed every 90 days, preferably 60 days, (5) Be changed if revealed or compromised, and (6) Be composed of characters from at least three of the following four groups from the standard keyboard:
   - Upper case letters (A-Z)
   - Lower case letters (a-z)
   - Arabic numerals (0-9)
   - Non-alphanumeric characters (punctuation symbols)
E. Workstation/Laptop encryption. All workstations and laptops that access the Medi-Cal website or process and/or store Medi-Cal PHI are recommended to be encrypted using a FIPS 140-2 certified algorithm, which is 128-bit or higher, such as Advanced Encryption Standard (AES); full disk encryption is recommended.

VI. The Provider/Representative agrees to pay the following fees associated with the use of the POS Network:

A. For eligibility transactions, including Share of Cost clearance and Medi-Service reservations submitted through Medi-Cal-provided phone lines, there will be no transaction fee.
B. For Provider and/or Representative submission of pharmacy claims transactions through Medi-Cal-provided phone lines, there will be a fee of $ .10 per approved claim transaction. An approved claim transaction is defined as a service, medical supply, durable medical equipment or drug supply that is determined to be payable through the claims adjudication process of the POS Network. This fee will be withheld from your regular Medi-Cal claims payment.
C. Any claim and/or eligibility transaction submitted on the Medi-Cal website will not have a transaction fee.
D. If the POS device is not being used over a reasonable amount of time, the Provider/Representative agrees to return the device. If the device is not returned in a timely manner, the Provider/Representative agrees to have the $700 cost of the device deducted from future reimbursement.

VII. Provider/Representative agrees, in order for the Provider/Representative's system to be activated for submission of actual Medi-Cal eligibility or claims-related transactions, to perform testing as required by DHCS and as documented in the *POS Network Interface Specifications* document or Medi-Cal website documents. Provider/Representative acknowledges that multiple tests may be required to activate the full functionality of the device/software/application and that all testing must be successfully concluded before the device/software/application will be activated.

VIII. Provider/Representative agrees to report all malfunctions of the POS Network or Medi-Cal website to Medi-Cal Fiscal Intermediary at the phone number and/or address listed below.

IX. Provider/Representative acknowledges that neither DHCS nor its agent is responsible for errors or problems, including problems of incompatibility, caused by hardware or software not provided by DHCS.

X. ***Provider or Non-Provider (Authorized Representative) Signature:***

I, the undersigned, am authorized and do attest and agree to all of the terms and conditions of this agreement.

Robert Parker
Printed Name of Signee

Authorized Signature

Vice President, Administrative Svc.
Title

02/08/16
Date

Address 2277 Napa-Vallejo Highway
Napa, CA 94558-6236

CMC Submitter Number (if applicable): ___ ___ ___

Please mail this completed form to:

Xerox State Healthcare, LLC
Attn: POS/Internet Help Desk
820 Stillwater Rd
West Sacramento, CA 95605
1-800-541-5555

ELECTRONIC HEALTH CARE CLAIM PAYMENT/ADVICE RECEIVER AGREEMENT (ANSI ASC X12N 835-Transaction)

TYPE OF AUTHORIZATION: [X] NEW [ ] CHANGE [ ] CANCEL

IDENTIFICATION OF PARTIES

This agreement is between the State of California, Department of Health Care Services (DHCS), hereinafter referred to as the Department, and the undersigned Provider.

PROVIDER INFORMATION

The Electronic Health Care Claim Payment/Advice Receiver Agreement (ANSI ASC X12N 835-Transaction) must be completed and submitted by an active Medi-Cal Provider. Rendering Providers will need to use the Group Provider Number. Non-providers can receive an 835-Transaction (per provider instruction); however, the authorizing Provider must submit the agreement. A letter of acknowledgement will be e-mailed to the provider when possible; otherwise, the letter will be mailed to the provider's service address.

Important Note: The following provider information must match the current information on file with DHCS Provider Enrollment, or the application will not be approved. To verify if the provider information is current, contact the Medi-Cal Fiscal Intermediary or the Department of Health Care Services, Provider Enrollment Division. If your file is not updated, submit a supplemental application form to DHCS Provider Enrollment Division.

PROVIDER NAME (full legal)		PROVIDER NUMBER	
Napa Valley Community College District		1538562996	
DBA (if applicable)		Last 4 digits of Tax Identification Number or Social Security Number 4463	
PROVIDER SERVICE ADDRESS (number, street) 2277 Napa-Vallejo Highway	CITY Napa	STATE CA	ZIP CODE 94558-6236
CONTACT PERSON Nancy Tamarisk			
CONTACT PERSON ADDRESS (number, street)	CITY	STATE	ZIP CODE
CONTACT PHONE NUMBER 707-256-7780	CONTACT EMAIL ADDRESS ntamarisk@napavalley.edu		

Note: Full legal name(s), assumed (DBA) name(s), and provider number(s) are required. The provider identified above will be hereinafter referred to as the "Provider."

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

RECEIVER INFORMATION

A Provider can designate up to two entities to receive an 835-Transaction. The two Receivers can be either the Provider or an outside party (such as a billing service, clearinghouse, or another provider), or up to two outside parties. A provider must have a business associate agreement with

outside parties who are designated to receive the 835-Transaction. This business associate agreement must be in compliance with 45 Code of Federal Regulations Section 164.504(e). A Provider designated as a Receiver will need an active Provider Number (Rendering Provider Numbers may not be used), and a Medi-Cal Point of Service (POS) Network/Internet Agreement Form on file or submitted with this agreement form. If a Computer Media Claims (CMC) Submitter Identification Number is used, a Medi-Cal Point of Service (POS) Network/Internet Agreement Form is not necessary. All non-providers authorized by the Provider to receive an 835-Transaction must have a DHCS-issued Computer Media Claims (CMC) Submitter Identification Number on file. If the non-provider does not have a CMC Submitter ID Number, they should contact the CMC Help Desk, (916) 636-1100 to request a CMC Application/Agreement Form. The CMC Application is also available at **www.medi-cal.ca.gov**.

The authorizing Provider must complete this section.

Receiver #1

RECEIVER NAME (full legal)	DBA (if applicable)	RECEIVER PHONE NUMBER	
Napa Valley Community College District		707-256-7780	
RECEIVER ADDRESS (number, street): 2277 Napa-Vallejo Highway	CITY: Napa	STATE: CA	ZIP CODE: 94558-6236
CONTACT PERSON: Nancy Tamarisk	RECEIVER ID: (PROVIDER # or CMC SUBMITTER ID#): 1538562996		

Receiver #2 (optional)

RECEIVER NAME (full legal)	DBA (if applicable)	RECEIVER PHONE NUMBER	
Medical Billing Technologies, Inc.		559-627-6267 ext. 210	
RECEIVER ADDRESS (number, street): 525 W. Main St., Suite F	CITY: Visalia	STATE: CA	ZIP CODE: 93291
CONTACT PERSON: Tiffany Ward	RECEIVER ID: (PROVIDER # or CMC SUBMITTER ID#): 7L0		

BACKGROUND INFORMATION

The Provider/Receiver agrees to provide the Department with the above requested information in order to verify qualifications to act as a Receiver of the 835-Transaction.

DEFINITIONS

The terms used in this agreement shall retain ordinary meaning except those terms defined in Title 22, *California Code of Regulations*, Section 51502.1, which may, from time to time, be amended.

CHANGE IN RECEIVING ELECTRONIC 835-Transaction

The Provider/Receiver and the Department agree that any changes in Provider/Receiver status, which might affect eligibility to receive 835-Transactions pursuant to Federal and State law, shall be promptly communicated to each party. Reference the Medi-Cal Provider Manuals 835-Transaction section for current procedures on the record update process.

CONFIDENTIALITY OF RECORD

The Provider/Receiver agrees to maintain adequate administrative, technical, and physical safeguards to protect the confidentiality of protected health information in accordance with State and Federal statutes and/or regulations, in particular 45 Code of Federal Regulations Parts 160 and 164. Any breach of security or unlawful disclosure of protected health information shall be

reported to the Department within 24 hours of the Provider/Receiver learning of such breach or disclosure and may be grounds for termination of this Agreement.

SCOPE OF SERVICE

The Medi-Cal Fiscal Intermediary agrees to supply to Provider/Receiver 835-Transaction Remittance Advice Detail (RAD) data for adjudicated Medi-Cal claims for Providers who have authorized the Department to send such information. The Medi-Cal Fiscal Intermediary will:

(a) Load weekly adjudicated Health Care Payment/Advice data (835-Transaction) to the Medi-Cal Internet Web site (**www.medi-cal.ca.gov**) by the Medi-Cal warrant date.

(b) Retain weekly adjudicated Health Care Payment/Advice data (835-Transaction) on the Medi-Cal Internet Web site for six weeks. For RAD data beyond six weeks, reference the Medi-Cal Provider Manuals for instructions to order a hard copy RAD. Hard copy RADs are required for Claims Inquiry Forms/Appeals.

(c) The Provider will receive an e-mail notification when the Electronic Health Care Claim Payment/Advice Receiver Agreement application is approved.

PROVIDER OBLIGATIONS

The Provider will:

(a) Complete and submit to the Medi-Cal Fiscal Intermediary an Electronic Health Care Claim Payment/Advice Receiver Agreement form for any additional receivers of 835-Transaction data. A Provider can designate up to two entities to receive an 835-Transaction. The two Receivers can be both the provider and an outside party (such as a billing service, clearinghouse, or another provider), or two outside parties. All non-providers that have been authorized by a provider to receive an 835-Transaction must have a Computer Media Claims (CMC) Submitter Identification Number on file and must have a business associate agreement in effect between the non-provider and the provider, which complies with 45 Code of Federal Regulations, Section 164.504(e).

(b) Ensure that a current and complete Medi-Cal Point of Service (POS) Network/Internet Agreement form and Electronic Health Care Claim Payment/Advice Receiver Agreement form are on file with the Medi-Cal Fiscal Intermediary.

(c) Not provide the data supplied under this Agreement to any third party except the applicable agents for whom the Provider has authorized to provide billing collection and/or reconciliation services and which have a business associate agreement in effect with the provider, in compliance with 45 Code of Federal Regulations, section 164.504(e). The Provider acknowledges that 835-Transaction data is confidential information owned by the State, the Medi-Cal Fiscal Intermediary, and/or applicable providers. This provision shall survive the expiration of this Agreement.

(d) Regardless of whether the Provider employs a third party Receiver to access the 835-Transaction, the Provider agrees to retain personal responsibility for the receipt of all Health Care Payment/Advice (835-Transaction) information.

(e) The Provider/Receiver agrees to use their DHCS-issued CMC Submitter Identification Number and Provider Identification Number (PIN) when accessing the Medi-Cal Internet Web site. The CMC Submitter ID Number will identify the Receiver and shall serve as acceptance to the terms and conditions of the Department's Telecommunications Provider and Biller Application/Agreement (DHCS Form 6153). The Provider further acknowledges the necessity of maintaining the privacy of the DHCS-issued CMC Submitter ID Number and agrees to bear full legal responsibility for use or misuse of the CMC Submitter ID Number and PIN if privacy is not maintained.

(f) Upon review of all 835-Transaction data, if the Provider/Receiver finds the data unreadable or incorrect, they are instructed to contact the Medi-Cal Fiscal Intermediary for resolution. Failure to report any such data inaccuracies shall constitute acceptance thereof.

(g) The Provider agrees to be responsible for the review and verification of the accuracy of claims payment information promptly upon the receipt of any payment. The Provider agrees to seek correction of any claim errors through the appropriate processes as designated by the Department or its Fiscal Intermediary including, but not limited to, the process set out in Title 22, California Code of Regulations, Section 51015, as, from time to time, amended.

EFFECTIVE DATE

This agreement shall become effective upon approval of the Department's authorizing agent.

TERMINATION

The Department or Provider may terminate this agreement with or without cause by giving 30 days prior written notice of intent to terminate, and the Provider has no right to appeal such termination by the Department. The Provider/Receiver has no right to appeal termination for cause pursuant to this subpart prior to the effective date of such termination. The Provider/Receiver may appeal any grievance resulting from the termination in accordance with the procedure established by Title 22, *California Code of Regulations*, Section 51015, as from time to time, amended.

PROVIDER/RECEIVER TO HOLD STATE OF CALIFORNIA HARMLESS

The Provider/Receiver agrees to hold the State of California harmless for any and all failures to perform by the Receiver services, software, or other features of 835-Transactions, which do not occur with paper (hard copy) Remittance Advice Details. The Provider/Receiver explicitly agrees that the Provider/Receiver assumes any and all risks that accompany receiving 835-Transactions, and that the Provider/Receiver is not relying upon the evaluation, if any, the State has made of the electronic receiver's system or software the Provider/Receiver is using. Provider/Receiver acknowledges that neither the Department nor its agent is responsible for errors or problems, including problems of incompatibility, caused by hardware or software not provided by the Department. Furthermore, the Provider/Receiver acknowledges that if the electronic Receiver system, software of Receiver contracted with, is or has been listed as available in Medi-Cal bulletins, that such listing was not an endorsement by the State of California nor does it imply that the service, system, or software has met or is continuing to meet a standard of performance.

LIMITATION OF LIABILITY

The Department shall not be liable to Provider or any authorized Receiver for any claim of, or damage or injury suffered by Provider or any authorized Receiver caused by the Department's delay in furnishing the data supplied hereunder. Moreover, neither party shall be liable for any damage amounts representing indirect, consequential (such as loss of business or loss of profits), or punitive damages.

Each party shall be excused from performance under this Agreement for any period and to the extent that it is prevented from performing; in whole or in part, as a result of delays caused by the other party, the State, or an act of God, war, civil disturbance, court order, labor dispute, or other cause beyond its reasonable control.

AGREEMENT BETWEEN PROVIDER AND ADDITIONAL THIRD PARTY RECEIVER (IF OTHER THAN THE PROVIDER OF SERVICE)

The Provider stipulates that any agreements with a Receiver to receive Medi-Cal 835-Transactions shall be in conformance with State and/or Federal law governing electronic transactions and shall contain provisions including, but not limited to, the following:

(a) The Provider shall specifically designate the Receiver as the agent of the Provider for the purpose of receiving 835-Transactions for the Provider. As the Provider's agent, the Receiver agrees to comply with all Medi-Cal requirements on record making and retention as established by statute and regulation including, but not limited to, Welfare and Institutions Code, Section 14124.1 and 14124 and Title 22, *California Code of Regulations*, Section, 51476. The Receiver also agrees to comply with state and federal laws on privacy of individually identifiable health information, including 45 Code of Federal Regulations Parts 160 and 164.

(b) The parties shall agree that the Department will make available 835-Transactions to additional Receivers only as long as the agreement between the Provider and the Receiver including the business associate provisions required by 45 Code of Federal Regulations Section 164.504(e), remains in existence and in effect.

The Provider is required to notify the Department in writing immediately upon any change in or termination of their agreement.

In addition to the electronic 835-Transaction, does the Provider want to continue to receive the hardcopy RAD (Remittance Advice Detail Summary)?

YES ☒ **NO** ☐

To be completed by Provider - CHECK APPROPRIATE BOX

☒ I hereby authorize the California Medicaid Program/Title XIX to load my 835-Transactions to the Medi-Cal Internet Web site – **www.medi-cal.ca.gov**.

☐ I hereby authorize the California Medicaid Program/Title XIX to update the previous 835-Receiver Agreement with the information on this form.

☐ I hereby cancel my 835-Transaction authorization.

PROVIDER SIGNATURE INFORMATION

FULL PRINTED NAME	TITLE
Robert Parker	Vice President of Administrative Services
PROVIDER SIGNATURE (ORIGINAL SIGNATURE REQUIRED; DO NOT USE BLACK INK) Robert W Parker	DATE 02/08/16

Please return to Medi-Cal Fiscal Intermediary, HIPAA Help Desk, P.O. Box 13029, Sacramento, CA 95813-4029.

This authorization remains in full force and effect until the California Medicaid Program/Title XIX receives written notification from the Provider of its termination, or until the California Medicaid Program/Title XIX or appointing authority deems it necessary to terminate the agreement.