Questions and Answers from the CRISS Toolkit Webinar
October 22, 2024

Questions from the "Authorizing Services" Section

1. **Q:** How do you authorize Emergency Department (ED) services?

   A: If the ED visit does not result in an inpatient stay, then a 01 authorization is issued to the outpatient facility. If the ED visit does result in an inpatient stay, then the Inpatient Service Authorization Request (SAR) and 01 Physician SAR will cover both the ED and inpatient stay. A separate outpatient facility SAR is not needed for the ED portion, because the ED physician can bill using the 01 physician SAR. (See page 20 and 29 of the toolkit for more information).

2. **Q:** What if the patient leaves the ED but then returns after 24 hours for the same issue and is admitted?

   A: If the patient returns after 24 hours, the first ED visit would need a 01 Facility SAR, and then the return would be covered under an Inpatient SAR and 01 physician SAR.

3. **Q:** If client is seen at the ED by a non-paneled MD and if patient is not admitted to the hospital, do we issue a SAR for emergency visit?

   A: If the ED visit is CCS medically eligible, then it can be covered using a 01 Facility SAR even if the MD is non-CCS paneled (see page 29 of Toolkit)

4. **Q:** How does CCS handle Denied (D) indicator CPT codes?

   A: If there is a D indicator, the code is valid but is not a covered benefit and the provider may not get paid. County System Administrators have the ability to override the system. They will be able to authorize the SAR. (CMSNet FAQ Manual, page 11). The provider must submit the claim with proof of medical necessity along with the SAR. It is not recommended this code be authorized unless the biller/provider is clear about the special billing requirements and understands CCS does not guarantee payment. This information should be included in the Special Instructions section of the SAR. Sample Special Instructions: "Procedure code (-----) has a pend/deny indicator of D. This code may not be a covered benefit. Client should not be billed if this code is denied." (ACSNet Manual, page 10).

   Note: If using the override function, it will override that code for all future requests for that code.

5. **Q:** My question is in regards to Neonatal Intensive Care Unit (NICU) where client is born in a Diagnosis-Related Group (DRG) hospital. When mother of client has Full Scope Medi-Cal through a Managed Care Plan (MCP), then the SAR submitted by the billing hospital is a SAR for Dates of Service starting on the date of birth of the baby, for one day, (for example 10/22 thru 10/23). We are receiving calls from a particular facility stating they are being denied payment because the SAR does not include the dates of service the baby was actually in the

NICU. However, this is the only DRG hospital having this issue. Please advise on how to deal with this billing issue.

A: Recommend to the provider to contact the Medi-Cal Telephone Service Center (1-800-541-5555) in situations like this where the county is following authorization guidelines, but the provider is not getting paid. Provider needs to provide the Remittance Advice Detail (RAD) number.

Note: Inpatient SARs for DRG hospitals, when they have an accompanying NICU Special Care Center, are covered under the mother's MCP. It covers the NICU stay for the month of birth and the following month (unless the newborn obtains their own coverage). The Program End date will have to be adjusted to include the NICU stay if the documentation shows the child meets NICU medical eligibility requirements.

Questions from the Medical Therapy Conference (MTC) Billing Section

6. **Q:** Can the CMS-1500 for the MTC claim be submitted electronically?

   A: No. The MTC has special rules for completion and submission. This claim requires a hard copy of an original CMS-1500 claim form. These rules are unique to CCS MTCs. Follow the step-by-step instructions for MTC Claim completion in the toolkit.

7. **Q:** What does it mean if a doctor receives a "warrant"?

   A: This means that the doctor has received a payment.

8. **Q:** Is there a specific envelope we are supposed to use?

   A: No, a standard envelope will work.

9. **Q:** Who can I contact for 1:1 assistance on the 1500 claim form

   A: Check the step-by-step instructions in the MTC Billing section of the toolkit, and if your question isn't answered please feel free to reach out for 1:1 assistance. The following Toolkit workgroup members are available:

   Dawn Pacheco, dpacheco@countyofglenn.net
   Meredith Wolfe, mwolfe@co.humboldt.ca.us
   Deb Webb, dwebb@buttecounty.net

10. **Q:** For the MTC claims, what address should be used in box 33? The physician's own address or the facility the physician works for, such as an outpatient department address?

    A: The physician's name and billing address that match the NPI # goes in box 33

11. **Q:** Just to clarify, can we submit a CMS-1500 electronically for any Medical Therapy Program services? For example, PT and OT services?

A: For Physical Therapy (PT) and Occupational Therapy (OT) services, the claim process is different. These can be submitted electronically. Some counties use CMS Net to submit PT and OT claims, and some counties use a third-party system for submitting these claims.

12. **Q:** What is the best way for the MTC Physician to access their RADs? Is the Medi-Cal Provider Portal the only way? It is cumbersome for some physicians.

    A: Yes, they would have to go through the Medi-Cal Portal. Medi-Cal stopped mailing these as of 2024, so now the only way to access them is through the portal.

13. **Q:** For MTC providers that work through a facility using the facility's address and the payments are confirmed on the MR940, is there a way to confirm if the payments have been received/processed by the facility? After the claims are verified on the MR 940, is there an additional step the MTC physician's facility need to do to receive the payment?

    A: The funds will be sent to the address on the CMS-1500. While we can see on the MR 940 that the claim has been paid, we do not know of a way to confirm that it has been received/processed by the facility other than asking the facility. The provider could contact the Medi-Cal Telephone Service Center (1-800-541-5555) to get confirmation.

Other questions

14. **Q:** Is there anyone that has a contact number for Provider Paneling at DHCS?

    A: 916-552-9105, option 5, and then option 2 from 8:00 AM to 5:00 PM Providerpaneling@dhcs.ca.gov

15. **Q:** Is there a resource available to determine if a family income is over $40,000 per year (9R) or under $40,000 per year (9U) or do we just rely on family income self-reporting using the Income Statement in CMSNet Correspondence?

    A: To determine if 9R or 9U should be assigned, the Income Statement in CMSNet Correspondence is the only resource available to CCS Programs

16. **Q:** For the 9R and 9U, if the county has access to income information through CALWIN or CALSAWS, are we allowed to use that resource if the family does not return the income info?

    A: Not without a release of information from the family, consenting to this.