Over One Year Claims Training

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Purpose/Objective

The purpose of this training is to provide the CRISS work group with an overview of the Medi-Cal Claim submission and timeliness guidelines.

Throughout this training we will review the following:

- Review claim submission guidelines
- Delay reason code and submission guidelines
- Over One Year guidelines
- Claim Follow-up Process
- Provider Relations Organization/Resources

Claim Submission Overview

Claim submission

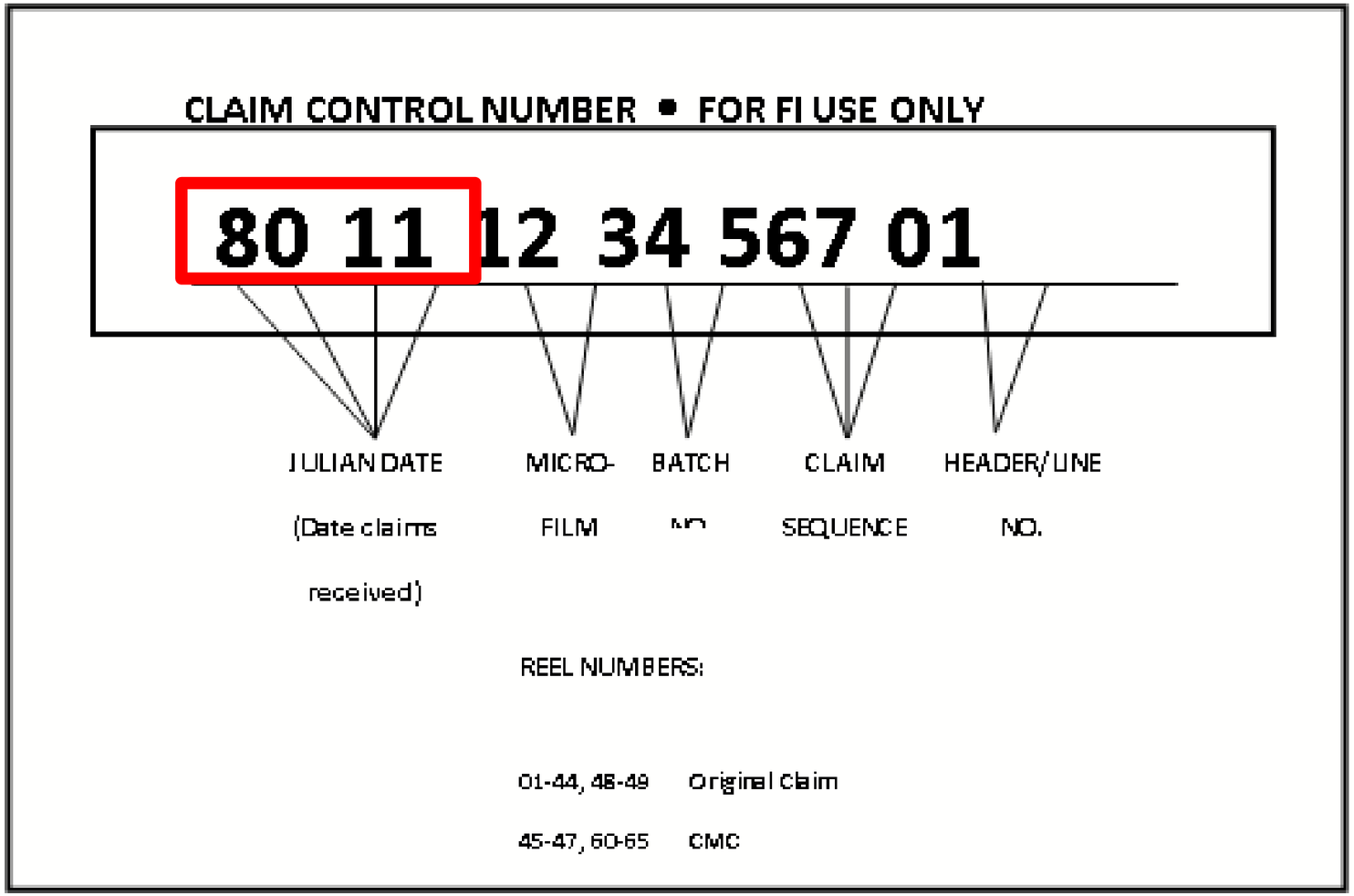
Medi-Cal fee-for-service claims are processed by the California MMIS Fiscal Intermediary using the Medi-Cal claims processing system. It is the intent of DHCS and the FI to process claims as accurately, rapidly and efficiently as possible.

Claim submission

A claim must be received within a specific time frame to process and adjudicate appropriately for payment or denial. The time frames are specific and need to be adhered to so that providers can receive timely reimbursement. Claims that have been adjudicated will be notified via the Remittance Advice Detail (RAD).

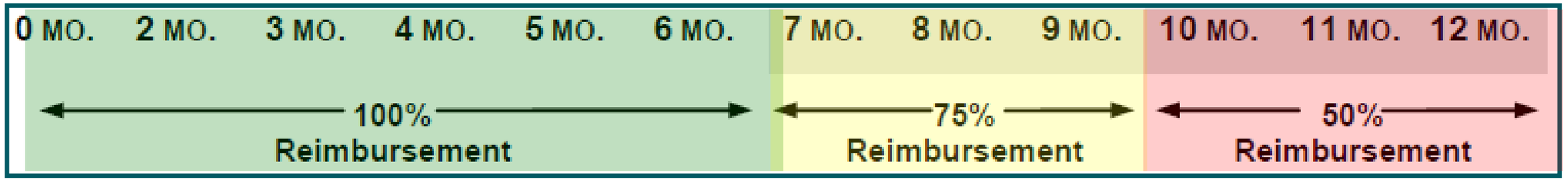
One the RAD a claim will be identified with a Claim Control Number(CCN). The CCN is used to identify and track Medi-Cal claims as they move through the claims processing system. This number contains the Julian date, which indicates the date a claim was received by the FI, and is used to monitor timely submission of a claim.

Claim submission



Claim Submission Timeliness Requirements

Original (or initial) Medi-Cal claims must be received by the Fiscal Intermediary (FI) within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit.



Claim submission

Claims entering the Medi-Cal system are processed on a line-by-line basis except for inpatient claims. Inpatient claims are processed on an entire claim basis. Each claim is subject to a comprehensive series of checks called “edits” and “audits.” The checks verify and validate all claim information to determine if the claim should be paid, denied or suspended for manual review. Edit/audit checks include verification of:

- Data item validity
- Procedure/diagnosis compatibility
- Provider eligibility on date of service
- Recipient eligibility on date of service
- Other insurance coverage or Medicare
- Claim duplication
- Authorization requirements

Delay Reason codes

Delay Reason codes

Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delay reasons allowed by regulations. Delay reasons also have time limits.

Although utilizing a Delay Reason Code designates an approved reason for late claim submission, delay reason code exception(s) also have time limits.

NOTE: Refer to the *CMS-1500 Submission and Timeliness Instructions* section (cms sub) or the *UB-04 Submission and Timeliness Instructions* section (ub sub) in the Part 2 provider manual.

Delay Reason codes

Delay Reason Code	Description
1	Proof of Eligibility (POE) unknown or unavailable
3	TAR approval delays
4	Delay by DHCS in certifying providers
5	Delay in supplying billing forms
6	Delay in delivery of custom-made eye appliances
7	Third party processing delay
10	Administrative delay in prior approval process
11	Other (e.g. theft); attach documentation justifying the delay reason
15	Natural disaster

Claims Over One Year

Claims Over One Year

Occasionally, a claim may be delayed more than one year past the date of service. The following list are possible scenarios that could result in a claim being submitted beyond one year:

- Third party decisions or appeals
- Determination of Medi-Cal eligibility
- *Treatment Authorization Request* (TAR) approval delay

Claims Over One Year

Providers may be eligible to receive 100% reimbursement of the Medi-Cal maximum allowable rate for claims submitted more than 12 months after the month of service if **Delay Reason Code 10** is utilized. Claims must be billed hard copy with appropriate attachments.

California MMIS Fiscal Intermediary
Over-One-Year Claims Unit
P.O. Box 13029
Sacramento, CA 95813-4029

Claims Over One Year

Cause of Delay	Delay Reason Code	Documentation Needed
Retroactive SSI/SSP	10	Copy of the original *County Letter of Authorization* (LOA) form (MC-180) signed by an official of the county.
Court order	10	Same as previous
State or administrative hearing	10	Same as previous
County error	10	Same as previous
Department of Health Care Services (DHCS) approval	10	Same as previous
Reversal of decision on appealed TAR	10	Copy of the TAR, copy of DHCS letter or court order reversing the TAR denial, and an explanation of the circumstances in the ***Additional Claim Information*** field (Box 19).
Medicare/Other Health Coverage	10	Copy of the Other Health Coverage *Explanation of Benefits* and an explanation of the circumstances in the ***Additional Claim Information*** field (Box 19).

Claims Over One Year

✓Claims submitted to the Over-One-year Claims Unit must include a copy of the recipient's proof of eligibility.

✓Claims and attachments more than a year old cannot be submitted electronically

✓Providers will not receive an acknowledgement or response letter for claims more than a year old.

✓Providers will receive a RAD message indicating the status of their claims.

Claims Follow-Up Process

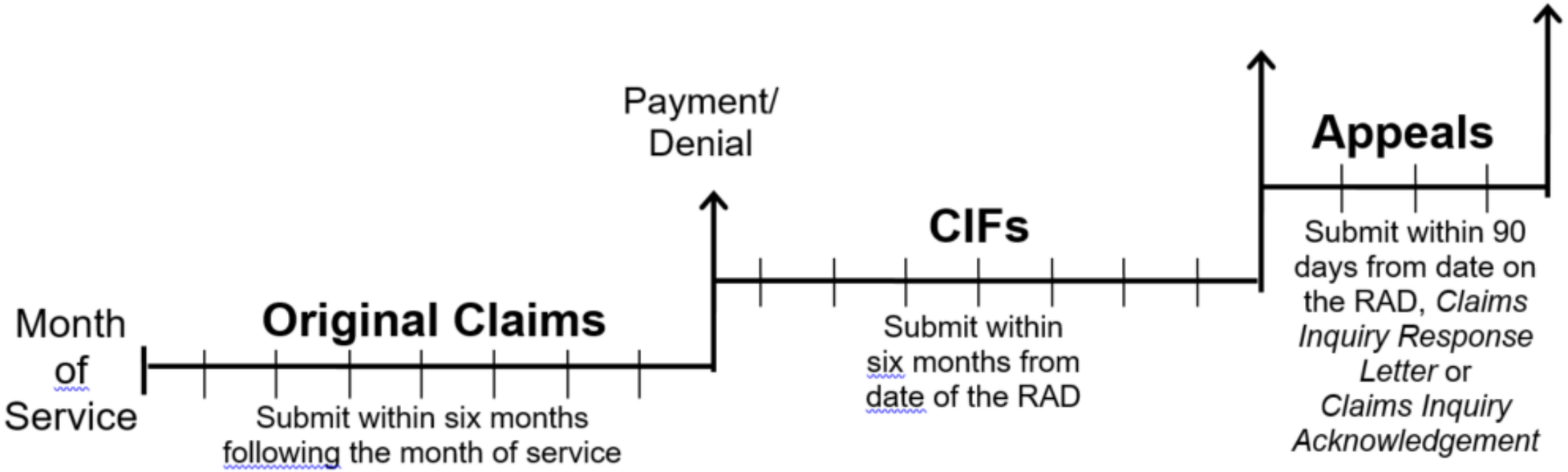
Claims Follow-Up Process

Medi-Cal claims may not process through CA-MMIS as providers anticipate; sometimes claims are suspended or denied. Some examples of why claims do not process correctly include:

- Minor information is missing
- Recipient information is incorrect

All claims go through a series of edits and audits before a claim is adjudicated. Depending on the reason a claim suspended or denied, the provider has the following follow-up actions:

Claims Follow-Up Process



Provider Relation Organization

Provider Relation Organization

The Provider Relations department is the primary liaison between the provider community and the Medi-Cal program. Provider Relations is responsible for:

- Answering provider billing questions
- Assisting providers in obtaining reimbursement for services
- Conducting provider training
- Informing providers about Medi-Cal policies and procedures
- Maintaining effective channels of communication among the Department of Health Care Services (DHCS), the California MMIS Fiscal Intermediary, Medi-Cal providers and their associations
- Recommending improvements to increase provider satisfaction with and participation in the Medi-Cal program

Provider Relation Organization

TSC — Telephone Service Center

- This unit is the first line of communication for the provider community

CSU — Correspondence Specialty Unit

- The CSU specializes in various claim types and conducts in-depth research.

O&E — Outreach and Education

- Provider inquiries that cannot be handled through the TSC or CSU are referred to a Regional Provider Relations Organization Representative.

Provider Relation Organization

TSC — Telephone Service Center

- 1-800-541-5555

CSU — Correspondence Specialty Unit

- Att: CSU P.O. Box 13029
  Sacramento, CA 95813-4029

O&E — Outreach and Education

- Contact TSC and request for a Regional Representative Request and provide them the detail of the type of training you would like. You must have an NPI in order for the Rep to come out to provider office to train.

Resource Information

- Medi-Cal Website (www.medi-cal.ca.gov)
  - Provider Manuals
  - Provider Bulletins
  - MCSS
  - Medi-Cal Learning Portal

- Seminar Training
- Webex Training
- Claims Assistance Room (C.A.R.)

Summary

- Review claim submission guidelines
- Delay reason code and submission guidelines
- Over One Year guidelines
- Claim Follow-up Process
- Provider Relations Organization/Resources