Medi-Cal Retroactive Claim Submissions

This training made possible by funding from the CMSP Governing Board
Presented by Penni Wright,
EDS/Medi-Cal, Provider Training
Introduction

• Some CMSP members may become retroactively eligible for Medi-Cal
• When retroactive Medi-Cal eligibility is granted, previously-paid CMSP claims may be recouped
• CMSP recoupment process instructs providers to bill services to Medi-Cal
Objectives

- Medi-Cal recipient eligibility verification process, managed care recipients
- Completion and submission of retroactive TARs
- SOC information and clearance
- Claim completion guidelines – beyond six-month billing limit
Objectives

• Claim completion guidelines – over-one-year claims
• UB-04 claim completion tips
• Claim requirements specific to FQHCs, RHCs, and IHS
• Resources available to providers
Recipient Eligibility

• Recipient eligibility is determined by the County Eligibility Worker

• Benefits Identification Card (BIC)
  – 14-character ID number
  – Date of birth
  – Date of issue
Recipient Eligibility

• Access eligibility information in the POS Network using information from the BIC

• POS Network
  – Telephone AEVS 1-800-456-2387
  – POS Device
  – Medi-Cal Web site www.medi-cal.ca.gov
Recipient Eligibility

• Eligibility information accessed from the POS Network
  – Eligibility for current and/or prior 12 months
  – Share of Cost/Spend Down Amount
  – Other health coverage
  – Prepaid Health Plan (PHP) status
  – Service restrictions
Recipient Eligibility

• Eligibility verification message includes
  – Aid code(s), defining specific services, programs or limitations
  – County code, identifying county of residence, managed care counties

• CMSP counties that are also Medi-Cal managed care: Marin, Napa, Solano and Sonoma
Recipient Eligibility Resources

• Part 1 provider manual
  – Eligibility: Recipient Identification (elig rec)
  – Aid Codes Master Chart (aid codes)
  – MCP: An Overview of Managed Care Plans (mcp an over)
  – MCP: County Organized Health System (COHS) (mcp cohs)
  – MCP: Prepaid Health Plan (PHP) (mcp pre)
Recipient Eligibility Resources

- Web site, Recipient Eligibility eLearning Tutorial (Education & Outreach, eLearning, Recipient Eligibility)

www.medi-cal.ca.gov
TAR Process

• Certain procedures require authorization
• All inpatient hospital stays require authorization
• Authorization is requested for emergency hospital admissions on the *Request for Extension of Stay in Hospital, 18-1*
TAR Process

• Inpatient procedures (as well as other procedures, services, equipment) are requested on the TAR (50-1)

• Elective admission for an inpatient hospital stay is initiated by the physician on the TAR (50-1)
TAR Exceptions

- TARs are not required for services rendered by FQHCs, RHCs, and IHS
- Documentation must be maintained in the patient’s record
Identification of Share of Cost (SOC)

• Medi-Cal recipients may be required to pay, or agree to pay, a monthly dollar amount toward medical expenses
• Determined by the County Social Services Department
• Based on income, SOC can change from month to month
• Refer to “share” in the Part 1 provider manual
Identification of SOC

• Providers access the Medi-Cal eligibility verification system:
  – POS device
  – Medi-Cal Web site
  – AEVS
  – State-approved vendor software
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<th>MEDICAL OFFICE</th>
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<tr>
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<td>01-02-08</td>
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<td>17:16:36</td>
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PROVIDER NUMBER: 0123456789

TRANSACTION TYPE: ELIGIBILITY INQUIRY

RECIPIENT ID: 91234567A

YEAR & MONTH OF BIRTH: 1966-12

DATE OF ISSUE: 11-01-07

DATE OF SERVICE: 01-02-08

LAST NAME: ROBERTS. MEDI-CAL RECIP HAS A $00050 SOC. REMAINING SOC $50.00.
Obligation of SOC

• Recipients may be allowed to pay at a later date or through an installment plan
• Clear obligated SOC amounts
• Obligation agreements in writing, signed by both parties
SOC Transactions

• Obligated/collectioned SOC is cleared in the Eligibility Verification System
• SOC transactions may be performed by providers retroactively, up to one year
• SOC transactions over one-year retroactive performed by the County Eligibility Worker
Certifying SOC

• Eligibility Verification System shows recipient paid/obligated the entire monthly SOC amount

• Claims for services prior to certification of SOC will be **denied**

• EVC/TRACE number, as well as eligibility information, service limitations, aid codes
Reversing SOC Transactions

- Enter the same information for a clearance
- Specify entry is a reversal transaction
- Once SOC is certified, reversal transactions can no longer be performed
Multiple Aid Codes

• Recipients may qualify for limited-scope Medi-Cal or programs other than Medi-Cal
• Aid codes identify additional programs or services
• May be required to pay SOC for some services and no SOC for other services
• CMSP aid codes: 84, 85, 88, 89, 8F and 50
LAST NAME: SMITH. EVC#: A999999999.
CNTY CODE: 33. 1ST SPECIAL AID CODE: 48. MEDI-CAL ELIGIBLE FOR PREGNANCY/POSTPARTUM RELATED MEDICAL SVCS W/NO SOC. FOR ALL OTHER MEDI-CAL SVCS, RECIP HAS SOC OF $00500. REMAINING SOC $500.00.
County Medical Services Program

- SOC calculated independently for CMSP and Medi-Cal
- Same income included in both calculations
- Same expense may be used to clear SOC for both CMSP and Medi-Cal
- **Two separate transactions**
- For retroactive Medi-Cal eligibility, may be necessary to submit a separate SOC transaction
SOC on the UB-04 Claim Form

- **Value Codes and Amount**, Box 39-41
- Code: “23”
- Amount: $50.00 collected entered as “5000”

<table>
<thead>
<tr>
<th></th>
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<th>40 VALUE CODES</th>
<th>41 VALUE CODES</th>
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SOC on the UB-04 Claim Form

- **Estimated Amount Due**, Box 55
- Difference of **Total Charges** less SOC amount

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<tr>
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The circled number 175000 represents the estimated amount due under box 55.
UB-04 Claim Completion

• Refer to Part 2 provider manual for detailed instructions:
  – “ub comp ip”
  – “ub comp op”

• Separate claims for inpatient and outpatient services

• Box 1: address including **9-digit ZIP** code, without the “-”
UB-04 Claim Completion

• *Type of Bill* code, Box 4
  – Two-digit facility code
  – One-character claim frequency code

• *Condition Codes*, Boxes 18-24
  – Do not enter Delay Reason code

• Box 37A, Delay Reason Code
UB-04 Claim Completion

• *Value Codes and Amounts (SOC)*, Boxes 39-41
• Outpatient claims, *Description*, Box 43, identifies service code in Box 44
• *Service Units*, Box 46, O/P units of service or I/P days of care, up to 99
• Enter “001”, line 23, Box 42 to designate total charges
UB-04 Claim Completion

- *Payer Name*, Box 54A-B, “I/P MEDI-CAL” or “O/P MEDI-CAL”
- *NPI*, Box 56, enter the correct NPI
- *Insured’s Unique ID*, Box 60A-C, enter the correct recipient ID number
- *Treatment Authorization Codes*, Box 63A-C, enter the 11-digit TAR Control Number
UB-04 Claim Completion

- Inpatient claims, Principal Procedure Code and Date, Box 74, enter the ICD-9-CM Volume 3 procedure code
- Attending Physician ID, Box 76, NPI number
- Operating Physician ID, Box 77, NPI number
- Other Physician ID, Box 78, NPI number of admitting physician for inpatient claims
UB-04 Claim Completion

• Remarks, Box 80, do not reduce font or abbreviate terminology – attachments if necessary

• Part 2 provider manual resources:
  – “ub spec ip”
  – “ub tips ip”
  – “ub spec op”
  – “ub tips op”
UB-04 Resources

• Call TSC at 1-800-541-5555
  – Option 15, then 15 again for inpatient/ outpatient claims

• Web site, Claim Form eLearning Tutorials (Education & Outreach, eLearning, UB-04 Claim Form Tutorial)
  www.medi-cal.ca.gov

• Call Blue Cross with questions about billing CMSP, 1-800-670-6133
RHCs and FQHCs

- Outpatient health care to recipients in rural and non-rural areas
- RHCs located in medically underserved areas
- FQHCs serving medically underserved populations
- Reimbursed on a Prospective Payment System
RHC and FQHC Covered Services

- Physician, physician assistant
- Nurse practitioner, nurse midwife
- Visiting nurse
- CPSP practitioner
- Licensed clinical social worker
- Clinical psychologist
- Adult Day Health Care
FQHC/RHC Authorization

• TARs and not required for services rendered by RHCs & FQHCs

• Maintain records with same level of documentation that is needed for TAR approval
FQHC/RHC “Visit”

- A face-to-face encounter between an RHC or FQHC recipient and a
  - Physician
  - Physician assistant
  - Nurse practitioner or certified nurse midwife
  - Clinical psychologist
  - Licensed clinical social worker
  - Visiting nurse
Qualifying Visits

• Encounters with more than one health professional on the same day, at a single location, constitute a single visit

• Two visits may be billed when:
  – Patient suffers illness or injury that requires another diagnosis or treatment
  – Patient receives ADHC or is seen by a health professional, and receives dental services
Services for Health Care Plan Recipients

• Bill the appropriate HCP for services to HCP recipients (Napa, Solano, Sonoma)

• Only services that are contractually excluded from the plan (ADHC) may be billed to EDS/Medi-Cal
Crossover Claims, RHC and FQHC

• Billing code “02” for Medicare/Medi-Cal crossover claims
• Under a PPS, the reimbursement rate for “02” will equal the difference between the federal Medicare payment and the provider’s PPS rate
• Provider must be a RHC or FQHC for Medicare as well as for Medi-Cal
RHC and FQHC Billing Codes

• RHC and FQHC codes
  – Per-visit code (01)
  – Crossover code (02)
  – ADHC codes (06, 07, 08, 09)
  – Services not covered by MCP (11, 12, 13, 15, 16, 17)
  – MCP differential rate (18)
IHS Covered Services

- Physician, physician assistant
- Nurse practitioner, nurse midwife
- Visiting nurse (in an area with a shortage of Home Health Agencies)
- Clinical psychologist
- Clinical social worker
- ... and more
IHS Medical Visit

• IHS clinics may be reimbursed for up to two visits a day, when
  – One is a medical visit (code 01), and
  – The other visit is another health visit (code 23), or a Medi-Cal ambulatory visit (code 24)
IHS Medi-Cal Ambulatory Visit

• Per-visit code 24
• Reimbursed at the HIS all-inclusive rate
  – Physical therapy, occupational therapy, speech pathology, audiology, podiatry, drug and alcohol visits, chiropractic, and acupuncture
IHS/MOA Per-Visit Codes

- All-inclusive per visit codes (codes 01, 02, 03, 04, 05)
- Services not covered by MCP (codes 11, 12, 13, 14, 15, 16, 17)
- MCP differential rate (code 18)
Six Month Billing Limit

• Original Medi-Cal claims must be received by EDS within six months following the month of service

• Refer to Part 1 provider manual, “claim sub”

• Claims submitted more than six months after the month of service:
  – Valid Delay Reason Code
Delay Reason Code #1

• Proof of Medi-Cal eligibility is unknown or unavailable

• In *Remarks*, Box 80, enter the month, day, and year when proof of eligibility was received
  – Claims received within 60 days of the date of eligibility verification (CMSP: date of the Blue Cross notice)
  – Proof of eligibility obtained from the POS Network within 1 year of the month of service
Delay Reason Code #1

• Requires attachments (proof of eligibility) that electronic claim format may not accommodate
• Bill electronically, using ASC 12N 837 v.4010A1
• Paper attachments to electronic claims using the Attachment Control Form
• Or, submit paper claim
Delay Reason Code Placement

- Box 37A (unmarked) of the UB-04 claim form
- Delay reason code documentation
Partial Claim Reimbursement

• Claims submitted between the seventh through twelfth month (without a delay reason code) are reimbursed at a reduced rate
  – 7-9 months: 75% reimbursement
  – 10-12 months: 50% reimbursement
  – Beyond 12 months: Zero reimbursement
Over-One-Year Claims

• More than one year past the date of service
  – Such as retroactive Medi-Cal eligibility
  – Submitted as Medi-Cal claims for the first time
• Use delay reason code **10**
• Send paper claims, with attachments
Over-One-Year Claims

• Send to:
  Over-One-Year Claims Unit
  P.O. Box 13029
  Sacramento, CA 95813-4029

• Attach County Letter of Authorization (LOA) form (MC-180) issued by the county welfare department with original signature
Over-One-Year Claims

• In Remarks (Box 80), enter the month, day, and year when proof of eligibility was received

• Submit claim within 60 days of the date eligibility was verified
Additional Resources

• Correspondence Specialist Unit
• Clarification about recurring billing issues
  – ATTN: CSU
  – P.O. Box 13029
  – Sacramento, CA 95813-4029
Additional Resources

• Regional Representatives
• One-on-one billing assistance
• Onsite visits
• Policy changes
• Call 1-800-541-5555 to speak with a TSC agent and request a Regional Representative onsite visit
Thank You!