Claim Submission and Timeliness Overview

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‹‹This manual section has been retained to provide reference to LTC-related billing instructions for dates of service prior to February 1, 2024. This manual section is not live and does not reflect current billing policy and should not be referenced when billing for dates of service on or after February 1, 2024. For current billing instructions as of February 1, 2024, refer to the appropriate manual section in the Long Term Care Provider Manual.››

This section includes information about claim forms that providers use to bill services rendered to recipients of the programs listed in this manual. In addition, this section includes basic claim form preparation instructions, claim submission deadline information and a brief description of claims processing procedures.

Introduction

Claim Forms Used to Bill Medi-Cal

The claim forms that providers use to bill Medi-Cal are listed below. The form a provider submits is determined by their Medi-Cal designated provider category and the service they render.

Table of Claim Forms Used to Bill Medi-Cal

Claim Form Used by (Provider Type)	Submit When Billing for:
CMS-1500 Claim: Allied Health, Medical Services Pharmacy, Vision Care	Medical services and supplies Vision Care services/eye appliances
Payment Request for Long Term Care (25-1): Long Term Care	Long term care services rendered in either a free-standing facility or distinct part of an acute inpatient facility
UB-04 Claim: Inpatient, Outpatient	Inpatient and outpatient services as follows: • Inpatient services for acute hospital accommodations and ancillary charges • Outpatient services for institutional facilities and for others, such as Rural Health Clinics (RHCs) and chronic dialysis services

ANSI and Medi-Cal Forms

The *CMS-1500* and *UB-04* claim forms were adopted by Medi-Cal in 2007 to comply with Federal and State regulations promoting uniformity in billing. These claim forms use the widely accepted American National Standards Institute (ANSI) format. The 25-1 claim form is unique to the Medi-Cal program and does not use the ANSI format.

Processing Claims

Introduction

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. A brief description of claims processing methods follows.

Computer Media Claims (CMC)

CMC bypass the claims preparation and data entry processes of hard copy claims and go directly into the claims processing system. This significantly reduces adjudication time.

Point of Service (POS) Network Claims

Some *CMS-1500* claims are submitted through the Medi-Cal Providers website or Medi-Cal Rx website. The *CMS-1500* online claim format includes an 80-character remarks field. Claims requiring additional documentation must be billed “hard copy” or through CMC.

Enrollment

To submit POS or CMC transactions on the Medi-Cal Providers website on behalf of a provider, submitters must register in the Medi-Cal Provider Portal and be affiliated to the provider.

Paper Claims

All incoming paper claims and other documents are pre-sorted by the U.S. Postal Service by P.O. Box and delivered to the FI mailroom by the Postal Service or FI couriers.

All submitted forms must be on standard paper claim forms. Standard claim forms can be purchased from authorized vendors. Accuracy, completeness and clarity of the form are necessary to ensure that the information is scanned correctly into the system.

Paper Claim Preparation

Paper claims routed to the Claims Preparation Unit are examined for acceptability and sorted for data entry. Claims and attachments are scanned, assigned a unique 13-digit Claim Control Number (CCN) and routed for either Optical Character Recognition (OCR) or Key Data Entry (KDE).

Neatly typed or computer-filled claim forms that have data within the boxes on the form are sorted for data entry by OCR scanners. All other claim forms are entered manually by KDE operators.

Claim Control Number

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. See Figures 1 and 2.

Julian Date

The Julian date within the CCN indicates the date a claim was received by the FI and is used to monitor timely submission. See Figure 1.

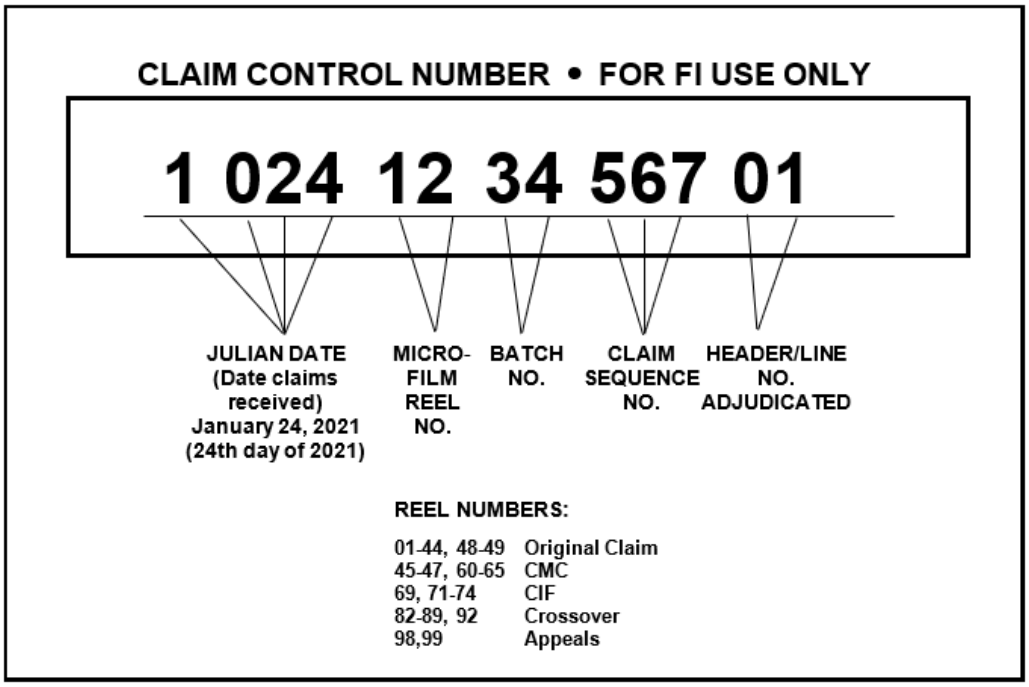

Figure 1: Claim Control Number (CCN)

Day Month	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
1.	1	32	60	91	121	152	182	213	244	274	305	335
2.	2	33	61	92	122	153	183	214	245	275	306	336
3.	3	34	62	93	123	154	184	215	246	276	307	337
4.	4	35	63	94	124	155	185	216	247	277	308	338
5.	5	36	64	95	125	156	186	217	248	278	309	339
6.	6	37	65	96	126	157	187	218	249	279	310	340
7.	7	38	66	97	127	158	188	219	250	280	311	341
8.	8	39	67	98	128	159	189	220	251	281	312	342
9.	9	40	68	99	129	160	190	221	252	282	313	343
10.	10	41	69	100	130	161	191	222	253	283	314	344
11.	11	42	70	101	131	162	192	223	254	284	315	345
12.	12	43	71	102	132	163	193	224	255	285	316	346
13.	13	44	72	103	133	164	194	225	256	286	317	347
14.	14	45	73	104	134	165	195	226	257	287	318	348
15.	15	46	74	105	135	166	196	227	258	288	319	349
16.	16	47	75	106	136	167	197	228	259	289	320	350
17.	17	48	76	107	137	168	198	229	260	290	321	351
18.	18	49	77	108	138	169	199	230	261	291	322	352
19.	19	50	78	109	139	170	200	231	262	292	323	353
20.	20	51	79	110	140	171	201	232	263	293	324	354
21.	21	52	80	111	141	172	202	233	264	294	325	355
22.	22	53	81	112	142	173	203	234	265	295	326	356
23.	23	54	82	113	143	174	204	235	266	296	327	357
24.	24	55	83	114	144	175	205	236	267	297	328	358
25.	25	56	84	115	145	176	206	237	268	298	329	359
26.	26	57	85	116	146	177	207	238	269	299	330	360
27.	27	58	86	117	147	178	208	239	270	300	331	361
28.	28	59	87	118	148	179	209	240	271	301	332	362
29.	29	N/A	88	119	149	180	210	241	272	302	333	363
30.	30	N/A	89	120	150	181	211	242	273	303	334	364
31.	31	N/A	90	N/A	151	N/A	212	243	N/A	304	N/A	365

Figure 2: Julian Date Calendar.

For Leap Year, add one day to the number of days after February 28.
Leap years: 2000, 2004, 2008

Claims Adjudication

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

Inpatient claims are processed on an entire-claim basis and also are subject to edits and audits.

Claims in Suspense

Claims that fail an edit or audit will suspend for review by a claims examiner who will identify the reason for suspense and examine the scanned image of the claim and attachments. If input errors are detected, the examiner will correct the error and the claim will continue processing. Claims requiring medical judgment will be reviewed by a physician or other qualified medical professional in accordance with the provisions of *California Code of Regulations* (CCR), Title 22 and policies established by the Department of Health Care Services.

Payment

Claims that pass edits and audits are listed on a payment tape and sent to the State Controller’s Office (SCO). The SCO generates a warrant and accompanying Remittance Advice Details (RAD).

Claim Denial

Claims that fail edits and audits are denied.

Preparing Claims

Paper Claims and Submission

When providers submit paper claims, they should send the original claim form to the FI and retain the copy for their records. Carbon copies and photocopies are not acceptable for claims processing.

Billing Services and Provider Responsibility

Providers are responsible for all claims submitted with their provider number regardless of who completed the claim. Providers using billing services must ensure that their claims are handled properly. Entities submitting claims for services rendered by a health care provider are subject to Medi-Cal suspension if they submit claims for a provider who is suspended from Medi-Cal. Medi-Cal applies the same claim preparation and submission policies to providers and provider billing services for all claims. For details about required registration with DHCS on hard copy billing, refer to "Enrolling Hard Copy Billing Intermediaries" in the *Provider Guidelines* section of this manual.

Submission Standards

Providers should not submit multiple claims stapled together. Each form is processed separately and it is important not to batch or staple original forms together. Stapling original forms together indicates the second form is an attachment, not an original form to be processed separately.

Postage and Surcharges

Correct postage must be affixed to all envelopes mailed to the FI. The FI cannot accept postage-due mail. Postal regulations require a surcharge for any envelope larger than 6 ⅛ x 11 ½ inches and weighing less than one ounce. The claims envelopes furnished by the FI are subject to this surcharge. To avoid the surcharge on claims envelopes, providers should enclose several claim forms per envelope, increasing the weight to one ounce or more. It is also recommended that envelopes be no more than ¼-inch thick.

Courier Services

Courier services should deliver to the FI:

California MMIS Fiscal Intermediary
820 Stillwater Road
West Sacramento, CA 95605

Telecommunication Claims

Telecommunication claims may be submitted Monday through Friday, 6 a.m. through 10 p.m. Claims received after 2 p.m. will be entered into the system for processing during the next business day. The telecommunications system is open on legal holidays but unattended by help desk personnel. For assistance, providers must call on the next business day, between the hours listed.

Note: Medi-Cal does not accept walk-up claims delivery service.

Timelines for Claims

Six-Month Billing Limit

Original (or initial) Medi-Cal claims must be received by the FI within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit. For example, if services are provided on April 15, the claim must be received by the FI prior to October 31 to avoid payment reduction or denial for late billing. See *Figure 3*. *Figure 4* diagrams the claim timeline that includes not only the initial claim submission but also follow up requests. Refer to the *CIF Overview and Appeal Process Overview* sections in this manual for more information.

Note: For the purpose of adjudicating claims, the "through" date of service will be used to determine timeliness of submission.

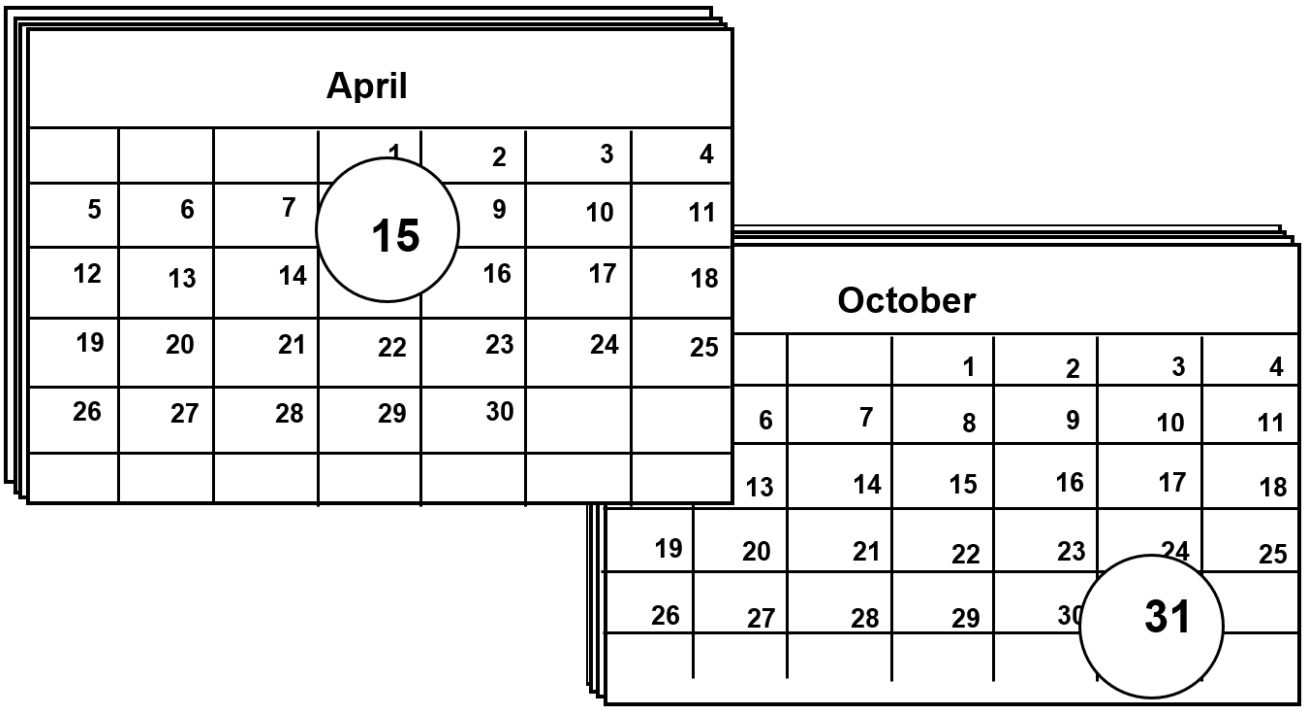

Figure 3: Six-month billing limit illustration

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 reason codes are used on claims to designate approved reasons for late claim submission. These delay reasons also have time limits. See the claim submission and timeliness instructions section of the appropriate Part 2 manual for details regarding delay reason codes.

Beginning with the month of service:

1. Submit the Original Claim within six months following the month of service
2. If the claim is denied, submit CIF within six months from date of the RAD
3. If the RAD is denied, submit the Appeal within 90 days from the date on the RAD, Claims Inquiry Response Letter or Claims Inquiry Acknowledgement

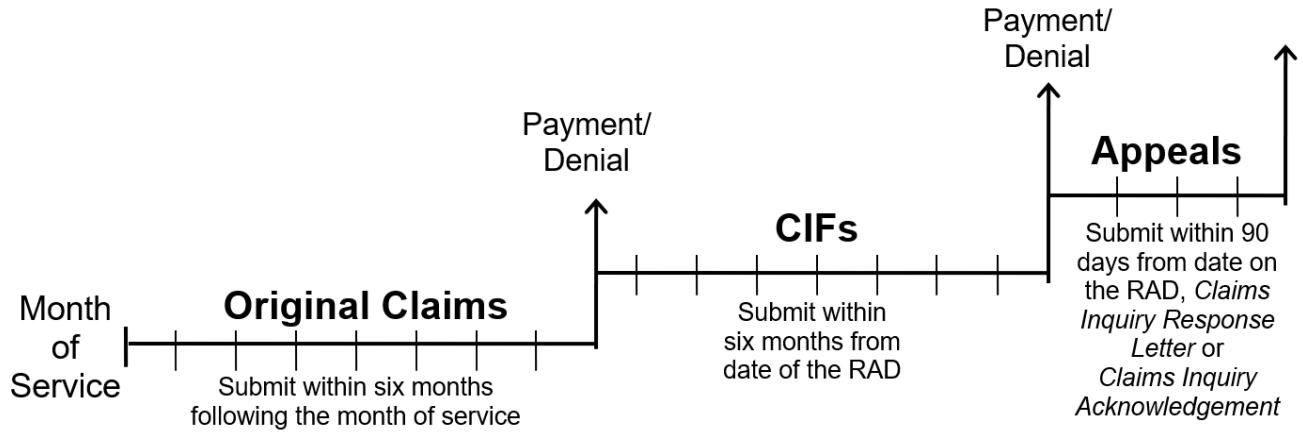

Figure 4: Claim Timeline Chart

Reimbursement Reduced

Claims that are not received by the FI within the for Late Claims six-month billing limit and do not meet any of the other delay reasons will be reimbursed at a reduced rate or will be denied as follows. See *Figure* 5.

- Claims received during the seventh through ninth month after the month of service will be reimbursed at 75 percent of the payable amount.
- Claims received during the tenth through twelfth month after the month of service will be reimbursed at 50 percent of the payable amount.
- Claims received after the twelfth month following the month of service will be denied.

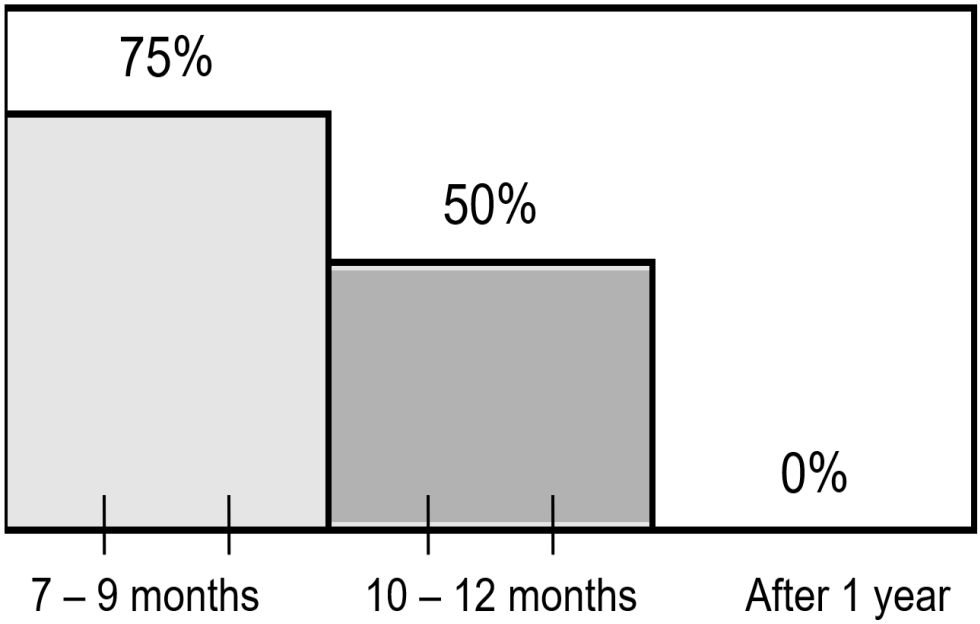

Figure 5: Claim reimbursement percentages when none of the delay reason codes apply.

Source: *Welfare and Institutions Code Section 14115*

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.