
CIF Submission and Timeliness Instructions

Page updated: August 2020

This section explains guidelines and time frames for submitting a *Claims Inquiry Form* (CIF). Refer to the CIF sections in this manual for additional billing information.

Introduction

Reconsideration of Denied Claims

The following timeliness requirements apply to CIFs requesting reconsideration of denied claims.

Within Six-Month Billing Limit

If a claim is denied and the date of service is within the six-month billing limit or the billing limit exceptions time frame, a corrected original claim form may be submitted instead of completing a CIF. Refer to the claim form submission and timeliness instructions section in the appropriate Part 2 manual.

Beyond Six-Month Billing Limit

Providers must file a CIF requesting reconsideration of a denied claim if the *Remittance Advice Details* (RAD) on which the claim appears is received after the six-month billing limit or the billing limit exceptions time frame. The CIF must be received by the California MMIS Fiscal Intermediary within six months from the date of the RAD on which the claim appears as denied. CIFs received after six months are subject to automatic denial.

Adjustments

Adjustments may be requested for underpaid and overpaid claims.

Underpaid/Overpaid Claims

A CIF requesting reconsideration of an underpaid claim must be received within six months from the date of the RAD. CIFs received after six months from the date of the RAD on which the underpayment was indicated are subject to automatic denial. CIFs for overpaid claims may be submitted at any time. For additional information, refer to “Underpayment and Overpayment Adjustments” in the *CIF Completion* section of this manual.

Tracers

Use the following guidelines when submitting a tracer:

- Do not submit a CIF to trace a claim appearing on a current RAD as “Suspends.” A suspended claim is pending adjudication and will appear on a future RAD as either paid or denied.
- Submit tracer requests separately from CIF adjustment requests and denial resubmissions.
- Do not send any documents with a tracer.

FI Acknowledgement of CIF

Claims Inquiry Acknowledgement

Within 15 days of receipt the FI will acknowledge requests for adjustments and reconsideration of denied claims with a *Claims Inquiry Acknowledgement* (see sample *Claims Inquiry Acknowledgement* on a following page in this section). The claim should appear on a RAD within 45 days after the *Claims Inquiry Acknowledgement* is received. The *Claims Inquiry Acknowledgement* serves as proof of timely submission if additional claim follow-up is needed. If the FI does not respond after the initial CIF is filed, providers should file an appeal.

«**Note:** *Claims Inquiry Acknowledgements* can be viewed electronically through the Medi-Cal Provider Portal.»

Claims Inquiry Response Letter

A *Claims Inquiry Response Letter* indicating the status of the claim is sent to providers when the CIF/tracer is processed. The letter includes a 13-digit Correspondence Reference Number (CRN), which contains the Julian date the CIF/tracer was received and can be used to verify that the CIF/tracer was submitted within the six-month billing limit.

If the response letter states the claim cannot be located, resubmit the claim as an appeal. Enclose any necessary attachments, including a copy of the *Claims Inquiry Response Letter*.

Providers may receive a *Claims Inquiry Response Letter* requesting additional information. To submit a new CIF, follow the instructions on the response letter.

«**Note:** *Claims Inquiry Response Letters* can be viewed electronically through the Medi-Cal Provider Portal.»

Additional Inquiries

Submitting Subsequent CIFs/Appeals

If further action is desired after a claim inquiry appears on the RAD as paid or denied, providers may submit either another CIF or an appeal.

All subsequent CIFs must be submitted within six months from the date of the RAD. An appeal must be submitted within 90 days. Include copies of all previous documentation with any CIFs or appeals submitted to substantiate timely follow-up (such as a *Claims Inquiry Acknowledgement*, *Remittance Advice Details* (RAD) or *Claims Inquiry Response Letter*).

CIF Submission

Documenting Timely Submission

The FI must receive a CIF or tracer within the same six-month billing limit as the original claim if the CIF or tracer is to be used to prove timely submission when filing an appeal.

Example: A service is provided on October 15, and a claim is completed and submitted on October 31. If the claim does not appear on a RAD by December 15, a CIF/tracer must be received by April 30 (six months from the month of service) to serve as documentation of timely submission. However, if the date of service is within the six-month billing limit or billing limit exceptions time frame, providers may submit a new claim.

Original CIFs

Only original CIFs are accepted for processing. Photocopied CIFs will be returned to providers.

Where to Submit CIFs

CIFs should be addressed to the FI at the following address:

California MMIS Fiscal Intermediary

P.O. Box 15300

Sacramento, CA 95851-1300



MEDI - CAL
FISCAL INTERMEDIARY
P.O. BOX 15300
SACRAMENTO, CA 95851-1300

ACKNOWLEDGEMENT ENCLOSED

PROVIDER NAME
999 W 99th ST

LOS ANGELES, CA 90007-3320

This notice acknowledges receipt to the claims inquiry referenced below. A detailed response to your inquiry will be sent to you as soon as possible. Further communication regarding this claims inquiry should include correspondence reference and document numbers.

STATUS: 1 – RECEIVED FOR CONSIDERATION OF DENIAL OR ADJUSTMENT

PROVIDER NAME

C/I LINE	PATIENT'S NAME OR MEDICAL RECORD #	PATIENT'S MEDI-CAL I.D. NUMBER	CLAIM CONTROL NUMBER	LINE	DATE OF SERVICE	NDC / UPN OR PROCEDURE CODE	MOD	STATUS
01	XXXXXXXXXX	XXXXXXXXXXXXXXXX	9999999999	XX	XXXXXX	XXXXXXXXXXXXXXXX		
02								
03								
04								

CORRESPONDENCE REF #	DOCUMENT NUMBER	PROVIDER NUMBER	DATE
XXXXXXXXXX	XXXXXXXX	XXXXXXXXXX	XXXXXX

Figure 1: Sample Claims Inquiry Acknowledgement

Status Numbers and Messages

One *Claims Inquiry Acknowledgement* is sent to providers for each CIF submitted. The upper table of the acknowledgement reflects all of the line information entered by a provider on the original CIF. This table's last column of each line displays a status number that translates into the following messages:

Status	Message
01	Accepted for resubmission of denied claim or underpayment/overpayment
02	Accepted. Tracer status letter will be generated.
03	Rejected. Only one CCN per crossover CIF allowed.
04	Rejected. Only one CCN per inpatient CIF allowed.
05	Rejected. Crossovers must be on a separate CIF.
06	Rejected. CMPND CIFs must be only CIF and line 01.

Status Inquiries

Providers may inquire about the status of a CIF by calling the Telephone Service Center (TSC) at 1-800-541-5555 and referencing the document number or Correspondence Reference Number (CRN) found at the bottom left portion of the *Claims Inquiry Acknowledgement*. The document number matches the document number at the upper right-hand corner of the CIF. Any written correspondence regarding claim lines referenced on a CIF acknowledgement should include copies of the *Claims Inquiry Acknowledgement* (or reference to the CRN and document numbers), CIF and all other pertinent documents.

<<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.