UB-04 Submission and Timeliness Instructions

Page updated: December 2023

‹‹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 provides procedures and guidelines for claim submission and timeliness (except for Local Educational Agency [LEA] providers). For specific claim completion instructions, refer to the *UB-04 Completion* sections of this manual.

Where to Submit Claims

Inpatient:

California MMIS Fiscal Intermediary
P.O. Box 15500
Sacramento, CA 95852-1500

Outpatient:

California MMIS Fiscal Intermediary
P.O. Box 15600
Sacramento, CA 95852-1600

Six-Month Billing Limit

Original (or initial) Medi-Cal claims must be received by the California Medicaid Management Information System (MMIS) 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. For example, if services are provided on April 15, the claim must be received by the California MMIS FI prior to October 31 to avoid payment reduction or denial for late billing.

Delay Reasons

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. See *Table 2: Delay Reasons* for a list of delay reason codes and required documentation.

Late Billing Instructions

Follow the steps below to bill a late claim that meets one of the approved exception reasons:

- Enter the appropriate delay reason code (1, 3 thru 7, 10, 11 or 15) in the *Unlabeled* field (Box 37A) of the claim.

- Complete the *Remarks* field (Box 80) of the claim with the information required for delay reason codes 1 (descriptions 1 and 2) and 3 thru 6.
- Attach substantive documentation to justify late submittal of the claim for delay reason codes 1 (description 3), 7, 10, 11 and 15. The *Delay Reasons* table on the following pages describes the documentation required for each delay reason.

Note: Delay reason codes 1 (description 3), 7, 10, 11 (description 1) and 15 require attachments to be sent. These codes require attachments that some electronic billing formats do not accommodate. Claims requiring attachments must be hard copy billed or electronically billed using the ASC 12N 837 v.5010 claim format with correlating attachments submitted with the *Medi-Cal Claim Attachment Control Form* (ACF). For more information regarding attachment submissions, refer to the *HIPAA 5010 Medi-Cal Companion Guide* under “Technical Specifications” on the Medi-Cal website at *www.medi-cal.ca.gov*.

Providers whose circumstances fall outside of established delay reason descriptions for claims submitted during the seventh through twelfth month after the month of service should enter an “11” in the *Condition Codes* field (Boxes 18 thru 24) of the claim.

Documentation Requirements

Documentation justifying the delay reason must be attached to the claim to receive full payment. Providers billing with delay reason code “11” without an attachment will receive reimbursement at a reduced rate or will be denied. Refer to “Reimbursement Reduced for Late Claims” in the *Claim Submission and Timeliness Overview* section of the Part 1 manual for more information.

Claims Over One Year Old

The California MMIS Fiscal Intermediary reviews all original claims delayed over one year from the month of service due to court decisions, fair hearing decisions, county administrative errors in determining recipient eligibility, reversal of decisions on appealed *Treatment Authorization Requests* (TARs), Medicare/Other Health Coverage delays or other circumstances beyond the provider's control. Claims submitted more than 12 months from the month of service must always use delay reason code "10" and must be billed hard copy with the appropriate attachments as listed in Table 1: Over-One-Year Billing Exceptions on a following page. These claims must be submitted to the following special address:

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

Note: Providers will receive a *Remittance Advice Details* (RAD) message indicating the status of their claim.

Claims submitted to the Over-One-Year Claims Unit must include a copy of the recipient's proof of eligibility and one of the following documents with the late claim.

Table 1: Over-One-Year Billing Exceptions

Cause of Delay	Delay Reason Code	Documentation Needed
Retroactive SSI/SSP	10	Copy of the original *Eligibility Letter of Authorization* (LOA) form (MC 180/ MC 180-2) or MEDS generated *Eligibility Letter of Authorization* signed by an official of the county, (three pages, all three pages are required) or Copy of the original county generated *Notification of Eligibility for Letter of Authorization*
Court order	10	Copy of the original *Eligibility Letter of Authorization* (LOA) form (MC 180/ MC 180-2) or MEDS generated *Eligibility Letter of Authorization* signed by an official of the county, (three pages, all three pages are required) or Copy of the original county generated *Notification of Eligibility for Letter of Authorization*
State or administrative hearing	10	Copy of the original *Eligibility Letter of Authorization* (LOA) form (MC 180/ MC 180-2) or MEDS generated *Eligibility Letter of Authorization* signed by an official of the county, (three pages, all three pages are required) or Copy of the original county generated *Notification of Eligibility for Letter of Authorization*

Note: Providers must bill Medicare or the Other Health Coverage within one year of the month of service to meet Medi-Cal timeliness requirements.

Table 1: Over-One-Year Billing Exceptions (continued)

Cause of Delay	Delay Reason Code	Documentation Needed
County error	10	Copy of the original *Eligibility Letter of Authorization* (LOA) form (MC 180/ MC 180-2) or MEDS generated *Eligibility Letter of Authorization* signed by an official of the county, (three pages, all three pages are required) or Copy of the original county generated *Notification of Eligibility for Letter of Authorization*
Department of Health Care Services (DHCS) approval	10	Copy of the original *Eligibility Letter of Authorization* (LOA) form (MC 180/ MC 180-2) or MEDS generated *Eligibility Letter of Authorization* signed by an official of the county, (three pages, all three pages are required) or Copy of the original county generated *Notification of Eligibility for Letter of Authorization*

Note: Providers must bill Medicare or the Other Health Coverage within one year of the month of service to meet Medi-Cal timeliness requirements.

Table 1: Over-One-Year Billing Exceptions (continued)

Cause of Delay	Delay Reason Code	Documentation Needed
Reversal of decision on appealed *Treatment Authorization Request* (TAR)	10	Copy of the TAR, copy of the DHCS letter or court order reversing the TAR denial, and an explanation of the circumstances in the *Remarks* field (Box 80) of the claim.
Medicare/Other Health Coverage	10	Copy of the Other Health Coverage Explanation of Benefits and an explanation of the circumstances in the *Remarks* field (Box 80) of the claim.

Note: Providers must bill Medicare or the Other Health Coverage within one year of the month of service to meet Medi-Cal timeliness requirements.

Claims Inquiry Form

The same follow-up guidelines apply to over-one-year-old and original claims when submitting a *Claims Inquiry Form* (CIF). Refer to the CIF *Submission and Timeliness Instructions* section of this manual for more information.

Table 2: Delay Reasons

Reason Code	Description	Documentation Needed
1	1. ∞Proof of eligibility unknown or unavailable. 2. *For obstetrical providers who are unable to bill for global services when patients leave their care before delivery. 3. ‡For Share of Cost reimbursement processing.	1. In the *Remarks* field (Box 80), enter month, day, and year when proof of eligibility (or retroactive eligibility) was received, for example, “Proof of eligibility received March 15, 2014.” 2. In the *Remarks* field (Box 80), enter the date that the patient left obstetrical care. 3. Attach a *Share of Cost Medi-Cal Provider Letter* (MC 1054) for SOC reimbursement processing.
3 *	TAR approval days.	In the *Remarks* field (Box 80), enter only the approval date of the TAR or CCS authorization.
4 *	Delay by DHCS in certifying providers.	In the *Remarks* field (Box 80), enter a statement indicating the date of certification.
5 *	Delay in supplying billing forms.	In the *Remarks* field (Box 80), enter a statement indicating the date billing forms were requested and date received.
6 *	Delay in delivery of custom-made eye appliances.	In the *Remarks* field (Box 80), enter a statement explaining why the appliance was not previously delivered to the recipient.
7 * + ‡	Third party processing delay. 1. Medicare/Other Health Coverage. 2. ▲Charpentier rebill claims.	With the Medi-Cal claim, submit a copy of the Other Health Coverage *Explanation of Benefits* or *Remittance Advice* showing payment or denial. Submit a copy of the *Remittance Advice* Details (RAD) for the original crossover claim.

Table 2: Delay Reasons (continued)

Reason Code	Description	Documentation Needed
10 ◊ ‡	Administrative delay in prior approval process. 1. Decisions/appeals. 2. Delay or error in the certification or determination of Medi-Cal eligibility. 3. Update of a TAR beyond the 12-month limit. 4. Circumstances beyond the provider's control as determined by DHCS.	Submit recipient proof of eligibility and the court order or fair hearing decision Submit a copy of the original *Eligibility Letter of Authorization* (LOA) form (MC 180/ MC 180-2) or MEDS generated *Eligibility Letter of Authorization* signed by an official of the county, (three pages, all three pages are required) (In the *Remarks* field [Box 80], indicate date received from the recipient.), or Copy of the original county generated *Notification of Eligibility for Letter of Authorization*. Submit recipient proof of eligibility and copy of the updated TAR. Submit recipient proof of eligibility with either a copy of DHCS approval or a copy of the Other Health Coverage (including Medicare) proof of payment or denial. **Note**: Claims submitted under this condition must have been billed to the OHC carrier within one year of the month of service.
11	Other 1. ⌂ ‡Theft, sabotage (attachment required). 2. †After six months, no reason. 3. *Late charges.	Attach documentation justifying the delay reason. Inpatient providers must use claim frequency code 5 when adding a new ancillary code to indicate a hospital stay that was billed when the original claim was submitted.
15 * ‡	Natural disaster.	Attach a letter on provider letterhead describing the circumstances and date of occurrence. The letter must be signed by the provider or provider's designee.

Electronic Resubmission for Inpatient Providers

To accommodate all diagnosis and procedure codes associated with an inpatient stay, inpatient providers may electronically resubmit the claim with claim frequency code “8” (void). Alternatively, providers may electronically resubmit the claim after the initial claim is voided with a *Claims Inquiry Form* (CIF) or *Appeal Form* through the following protocol:

- Submit the follow-up claim as an electronic claim
- If the claim “Admission Date” is more than six months before the date of claim resubmission, providers should submit their PDF RAD to support timeliness follow-up through the ACF process. The RAD must show the previously voided claim processed with a CIF or *Appeal Form*, and the date of the RAD must be within six months of the new claim.

  For more information regarding attachment submissions, refer to the billing instructions in the *HIPPA 5010 Medi-Cal Companion Guide*. This guide is available under the Technical Specifications heading on the HIPAA: 5010/NCPDP D.0 & 1.2 page of the Medi-Cal website (www.medi-cal.ca.gov).
- The following statement must be in the *Remarks* field (Box 80):

  “DRG claim required electronic submission to accommodate all the diagnosis/surgical procedure codes associated with this inpatient stay. A paper RAD to support timeliness follow-up submitted with ACF.”

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.
*	Claims related to these circumstances must be received by the California MMIS Fiscal Intermediary no later than one year from the month of service.
‡	Must be hard copy billed using the *UB-04* claim form or electronically billed using the ASC X12N 837 v.5010 transaction with correlating attachments submitted with the *Medi-Cal Claim Attachment Control Form* (ACF).
▲	Charpentier rebill claims must be received within six months of Medi-Cal RAD date for the original crossover claim.
+	Claims related to these circumstances, together with the Medicare or Other Health Coverage *Explanation of Benefits* or *Remittance Advice* or denial letter, must be received by the Other Health Coverage carrier no later than 12 months after the month of service and by the California MMIS Fiscal Intermediary within 60 days of the other health carrier's resolution (payment/denial).
∞	Claims related to this circumstance must be received by the California MMIS Fiscal Intermediary no later than 60 days after the date indicated on the claim that proof of eligibility is received by the provider. Proof of eligibility must be obtained no later than one year after the month in which service was rendered.
⌂	Claims related to these circumstances must be received by the Department of Health Care Services (DHCS) CAMMIS Division, Provider Services Section; MS 4716; 830 Stillwater Road, West Sacramento, CA 95605 no later than one year from the month of service.
◊	Claims related to these circumstances must be received by the CA-MMIS FI, Over-One-Year Claims Unit; P.O. Box 13029; Sacramento, CA 95813-4029 no later than 60 days after the date of resolution of the circumstance which caused the billing delay.
†	Claims related to these circumstances will be reimbursed at a reduced rate according to the date the claim was received by the California MMIS Fiscal Intermediary. Refer to "Reimbursement Reduced for Late Claims" in the *Claim Submission and Timeliness* section in the Part 1 manual.