‹‹Billing Instructions: Acceptable Claims, Attachments and ASC X12N 837 v.5010 Claims››

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‹‹ASC X12N 837 v.5010 claims are processed through the same claim verification programs as paper claims. The 837 claims and paper claims must meet the same edit and audit requirements.››

‹‹Claims Acceptable Through the 837 Formats››

‹‹The 837 claims can be submitted through EDI Submission on the Medi-Cal Provider Portal.›› This includes claims submitted within the six-month billing limit or claims submitted beyond the six-month billing limit with the appropriate billing limit exception code. ‹‹Denied claims resubmitted within the six-month billing limit also are acceptable for 837 submission.››

Delay Reason Code

‹‹The 837 claims format uses delay reason codes 1, 3 thru 6, 10 and 11.›› Refer to the appropriate *Submission and Timeliness* section of the Part 2 provider manual for delay reason code descriptions.

Supporting Documentation – Notes

Certain Medi-Cal claims require supporting documentation that can be noted in the *Remarks* field/*Additional Claim Information* field (Box 19) of the paper claim. ‹‹These claims also are acceptable for 837 claim submission and require using the 837 *Note (NTE) Segments*. The following list represents some of the circumstances under which claims may be submitted with appropriate substantiating statements in the *Note (NTE) Segments*.››

- When billing with certain HCPCS or CPT-4 codes, including:
  - ‹‹Unlisted Procedures, include procedure description and price in the *Note (NTE) Segments.*››
  - ‹‹Unlisted Injections, include name of drug, strength, dosage and invoice cost in the *Note (NTE) Segments.*››
  - ‹‹“By Report” Procedures, include additional clinical information or report in the *Note (NTE) Segments*.››
  - ‹‹Unusual/Complicated Procedures, include complicating or unusual circumstances in Procedures *Note (NTE) Segments*.››

- When billing with multiple or “By Report” modifiers (for example, -99, -51, -22).
- ‹‹When submitting claims using delay reason codes 1, 3 thru 6, 10 or 11 for the 837 claims format.
- When submitting claims requiring a Medical Service Reservation.››
- When submitting claims for Medicare non-covered services.
- When billing for a newborn using the mother’s Medi-Cal identification number.
- When including an emergency statement.
- When submitting Long Term Care claims detailing Share of Cost expenditures.

Supporting Documentation – Attachments

Certain Medi-Cal claims require supporting documentation that cannot be noted in the *Remarks* field/*Additional Claim Information* field (Box 19) but must be submitted as an attachment. ‹‹These claims can be submitted electronically using the 837 claim file format. There are three methods for sending in attachments with a claim:››

- Paper attachments can be mailed to Medi-Cal with an Attachment Control Form (ACF) cover sheet. The ACF contains an Attachment Control Number (ACN) used to link the attachment to its respective electronic claim. ‹‹The ACN must be entered in the *ASC X12N 837 v.5010 Paperwork (PWK) Segments*.››
- Faxed attachments can be sent to Medi-Cal with the ACF as a cover sheet and the ACN that links the attachment to its respective electronic claim. The ACN from the corresponding ACF must be entered in the *ASC X12N 837 v.5010 Paperwork (PWK) Segments*. Each fax must be sent separately and must include one ACF followed by the corresponding pages of the attachment. The fax number is 1-866-438-9377.

  Electronic attachments can be sent to Medi-Cal by an approved third-party vendor who will preprocess the attachments and submit them on behalf of the provider. ‹‹For electronic attachment submissions, the ACN will be supplied to the provider by the vendor and must be entered in the 837 *Paperwork (PWK) Segments.*››

‹‹Examples of claims submitted through 837 with separate attachments include:››

- Claims that require an Explanation of Medicare Benefits, Medicare Remittance Notice or Remittance Advice (Medicare status codes 1 thru 7 and 9).
- Claims that include denials from other health coverage carriers such as CHAMPUS, Kaiser, Ross Loos or prepaid health plans.
- Claims billing HCPCS or CPT-4 codes where the price is not listed with Medi-Cal.
- ‹‹The submitter is unable to include the pricing information for the *Note (NTE) Segment*.››
- Claims requiring sterilization or hysterectomy consent forms

Attachment Control Form: Required and Optional Fields

1. The Provider Number is a required field and must be clearly printed in the box provided.
2. The Provider Name is an optional field but is recommended for purposes of timely communication with the submitter, if needed.
3. The Provider Address is an optional field but is recommended for purposes of timely communication with the submitter, if needed.
4. The Provider Signature is a required field that must be completed by the provider.
5. Forms and attachments can be mailed to the address shown on the ACF or faxed to 1-866-438-9377. Each fax must include an ACF as the cover page followed by the corresponding attachment pages. Additional ACFs and attachments must be faxed separately.

MEDI-CAL CLAIM ATTACHMENT CONTROL FORM
STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

DO NOT WRITE IN THIS SPACE

ATTACHMENT CONTROL NUMBER 99999999999

VOID

1 PROVIDER NUMBER : (REQUIRED)
2 PROVIDER NAME :
3 PROVIDER ADDRESS :

(PLEASE PRINT IN BLACK OR BLUE INK TO COMPLETE THIS FORM)

FOR F.I. USE ONLY
1 2 3 4

5 RETURN THIS FORM WITH ATTACHMENTS TO:
FISCAL INTERMEDIARY
P.O. BOX 526022
SACRAMENTO, CA 95852

4 PROVIDER SIGNATURE DATE
X

USE THIS FORM AS A COVER SHEET FOR PAPER DOCUMENTATION TO SUPPORT THE ELECTRONICALLY SUBMITTED CLAIM.
FOR FURTHER INFORMATION REGARDING USE OF THE ATTACHMENT CONTROL FORM SEE THE PROVIDER MANUAL.

FORM NUMBER ACF-001

Attachment Control Form (ACF) Guidelines

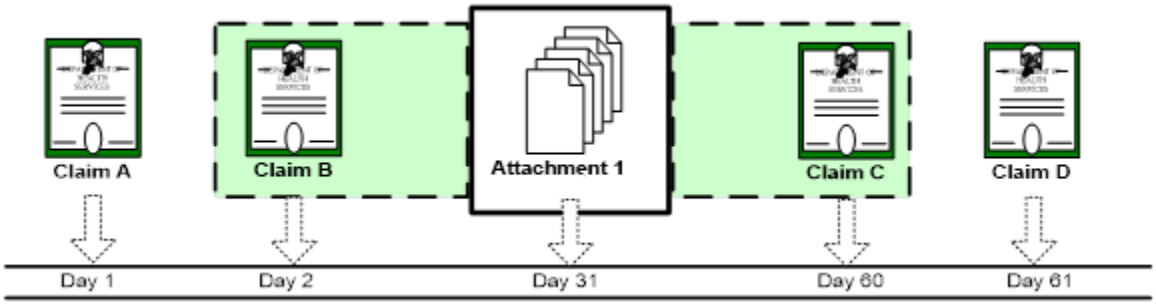
The ACF must be an original form obtained from Medi-Cal. Copies of the ACF will not be accepted.

The DHCS Fiscal Intermediary (FI) must receive the ACF and attachments within 30 days after or before the electronic claim submission date. See example below.

The 30-day “window” is based on the day the attachment or claim is received by the FI. Medi-Cal is not responsible for any postal delays in receiving the attachments.

The following example illustrates the timeframe limitations for accepting attachments for claims.

Submitting Attachments for Electronic Claims: Time Limitations



In this example, the Provider submits four claims, which are received over a period of 61 days. All four claims require the same attachments.

Day 1: Claim A received ACF and attachments for Claim A must be received by Day 30.

Day 2: Claim B received. ACF and attachments for Claim B must be received by Day 31.

Day 31: ACF/Attachment 1 received. Since it was received more than 30 days after Claim A, Claim A will be denied. It can be matched to Claim B, since it was received within 30 days of Claim B.

Day 60: Claim C received. Since it was received within 30 days of ACF/Attachment 1, the attachments can be matched to Claim C.

Day 61: Claim D received. Since this is more than 30 days after ACF/Attachment 1 was received, the attachments cannot be matched to Claim D, which will be denied.

Note: In the example above, Claims A, B, C and D could be different claims, or these four claims could include resubmissions of the same claim. In either case, all of the claims could use the same ACN.

TAR Approval

‹‹Claims for services that require a *Treatment Authorization Request* (TAR) are acceptable through 837 submission.›› The TAR Control Number is included in the claim record as indicated in the record data specifications outlined in this manual. The provider keeps a copy of the approved TAR on file.

‹‹Claims Unacceptable Through 837 Submission››

All claims requiring special processing must be submitted on paper claim forms, including:

- Medicare/Medi-Cal crossover claims that must be separately billed to Medi-Cal.
- Claims over one year old.
- Claims for Medi-Cal recipients who have a California Children Services (CCS)-eligible condition and who are enrolled in a managed care plan that excludes treatment of CCS-eligible conditions from the plan's contract rate. These claims will be denied if submitted directly to the DHCS FI. They must be submitted to the appropriate CCS office to ensure all necessary authorizations are included. Refer to the *California Children Services (CCS)* and the *Genetically Handicapped Persons Program (GHPP)* sections in the appropriate Part 2 manual for additional information.
- Vision care claims for eye appliances requiring prior authorization.
- Children's Treatment Program (CTP).

Submission Balancing

Each submission is balanced by comparing the total number of claims and dollars submitted to the total number of claims and dollars processed.

Billing Value Field

For balancing purposes, a *Billing Value* field is used to determine the total dollars billed. The *Billing Value* field for submitter and provider control records is defined as follows.

Submitter Control Records (created): The submitter *Billing Value* is the total of the individual *Billing Value* fields on each *Provider Control Record*.

Provider Control Record (created): The *Billing Value* is the total of all *Amount* fields for that provider and claim type as defined below:

- Medical/Allied/Vision: *Net Amount Billed*
- Outpatient: *Net Amount Billed*
- Inpatient: *Net Amount Billed*
- LTC: *Net Amount Billed for Each Line*

Rejected Submissions

‹‹The entire 837 claim submission may be rejected, if a balancing or data error is located in the *Submitter Control Record*.›› If the error is located in a *Provider Control Record*, claims for that particular provider will be rejected. If an error is located in a *Claim Record*, only that particular claim will be rejected.

Note: ‹‹Submitters should contact the EDI Help Desk by calling the Telephone Service Center (TSC) at 1-800-541-5555 for details about rejected submissions.

Test and production submission error information can be accessed on the Medi-Cal Provider Portal. Please refer to the *Provider Portal User Guide: Submitter Organization* for transaction testing information.››

Complete File Rejection

‹‹When an entire submission containing Medi-Cal claims fails 837 edit requirements, the submitter is contacted by phone and given the errors from the *Volser Summary* and *Error* reports. The *Volser Summary* and *Error* reports can be downloaded in the EDI Submission application in the Medi-Cal Provider Portal response table.

Note: Test and production submission error information can be accessed on the Medi-Cal Provider Portal. Please refer to the *Provider Portal User Guide: Submitter Organization* for transaction testing information.

Submitters should contact the EDI Help Desk by calling the Telephone Service Center (TSC) at 1-800-541-5555 for assistance with rejected submissions.››

Partial Rejection

‹‹Partially rejected claims at the provider or claim record level are shown in the *Volser Summary* report.›› The submitter should make the appropriate corrections and resubmit the corrected claims.

Note: ‹‹Submitters may contact the EDI Help Desk by calling the Telephone Service Center (TSC) at 1-800-541-5555 for details about rejected submissions.››

‹‹ASC X12N 837 v5010: Inpatient/Outpatient/LTC and Medical/Vision Services››

Submission Methods

‹‹The 837 claim may be submitted through the Medi-Cal Provider Portal for providers who bill inpatient, outpatient, long term care, vision, medical and allied health claim types. The 837 Medi-Cal specific requirements for the transaction records and some formatting is described in the *Medi-Cal EDI Companion Guide*. Data elements included in a submission are required for either ASC standard transactions or Medi-Cal claims processing.››

For an explanation of the ASC 5010 standards and various data values, refer to the HIPAA 5010 Consolidated Guides and the Technical Reports – Type 3 (TR3) documents found on the Washington Publishing Company website.

‹‹Medi-Cal's 837 file transfer procedures and submission protocol do not change with 837 submissions.››

Submission Balancing

‹‹Each 837 claim is verified by the *Receiver ID* on the transaction. Claim totals must balance with the claim record received. For balancing purposes, any 837 claim that is not processed in its entirety will be rejected.››

Rejected Submissions

‹‹The entire 837 claim submission will be rejected if the *Receiver ID* is not "610442" and all claims on a transaction are not processed.››

Production Errors, RADS and CIFS

Production Errors and Solutions

‹‹The 837 submissions are reviewed for production errors. Providers will be notified of formatting infractions by one of the following methods.››

Submission Error Notification

‹‹The EDI Help Desk staff notifies the submitter by phone each time a Notification production error is encountered.

Note: Submitters can also access submission error information on the Medi-Cal Provider Portal.››

Six-Month Billing Limit

Errors indicated should be corrected and the claim(s) resubmitted within the original six-month billing limit.

Production Claim Failure: Common Causes and Solutions

‹‹The *Production Claim Failure: Common Causes and Solutions (Chart 1* and *Chart 2)*, found on a following page, are a listing of common submission, production data and file errors with corresponding solutions. Submitters may also call the EDI Help Desk for help in correcting production and submission errors.

Remittance Advice

ASC X12N 835 Transaction

The Health Care Claim Payment / Advice 835 transaction is available on the Medi-Cal Provider Portal. The 835 is available by the Medi-Cal warrant date. Contact the EDI Help Desk for information about the 835 transaction or refer to the *Remittance Advice Details (RAD): Electronic* section in the Part 1 manual.››

Remittance Advice Details (RAD)

‹‹RAD statements include all provider claims submitted by telecommunications and hardcopy. The 837 claims are identified by reel numbers 45 through 47 and 60 through 65 in the fifth and sixth digits of the Claim Control Number (CCN).››

Supplemental Claims Payment Information (SCPI)

‹‹Electronic RAD files can be downloaded from the Medi-Cal Provider Portal through a separate contract with the DHCS FI. Contact the EDI Help Desk for further information concerning Supplemental Claims Payment Information (SCPI) or refer to the *Remittance Advice Details (RAD): Electronic* section in the Part 1 manual.››

Claims Inquiry Form

Resubmission of claims denied for exceeding the six-month billing limit or adjustments to previously paid claims can be done electronically (or) through a *Claims Inquiry Form* (CIF). For more information regarding the CIF process, please refer to the *CIF Overview* section in the Part 1 manual.

Note: ‹‹If a claim is denied for exceeding the six-month billing limit because the billing limit exception code or substantiating remarks text was missing from the original 837 submission, the claim may be corrected and resubmitted through the Provider Portal.

Claims excluded from 837 billing for one of the above reasons are denied with Remittance Advice Details (RAD) code 263 and the following message:››

> Resubmit claim with required attachments; Medi-Cal: attach invoice or other justification; Crossover: attach RA/EOMB/MRN.

Production Claim Failure: Common Causes and Solutions

Claims Certifications and Solutions Table

Claims Certification (Medi-Cal Submissions)	Solutions
Total Claim Records does not agree with the total of the *Number of Claims* for each provider ID.	Ensure accuracy of addition and ensure that numbers are not transposed.
Submitter number and/or *name* and *address* are missing.	Ensure all fields are completed.
If a photocopy of the form is submitted, copy does not include both sides of document and/or original signature.	Ensure that both sides of the form are photocopied and submitted and that the copied form includes an original signature.

Medi-Cal Data Errors and Solutions Table

Medi-Cal Data Errors	Solutions
Claim count or billed amount on the *Submitter Control Record*, the *Provider Control Record(s)*, and/or the *Claim Records* does not balance.	All claim controls and billed amounts on a file must balance.
Line number outside valid range for claim type. ‹‹This refers to Medi-Cal 837 claim formats (all claim types)››.	Valid detail line numbers for claim types are: 01 - 06 Long Term Care 01 - 15 Inpatient 01 - 14 Outpatient 01 - 08 Medical
Duplicate *Provider Control Records.*	There may be only one *Provider Control Record* for each provider number/claim type combination.

Medi-Cal Data Errors and Solutions Table (continued)

Medi-Cal Data Errors	Solutions
Submission date exceeds process date.	This error often results from the assumption that the submission date is the date the DHCS FI will process the file. ‹‹Avoid this error by using the date when 837 files are created.››
Provider not in active status.	‹‹Do not submit claims for providers who are pending approval for 837 billing. This causes provider's claims to reject.››

‹‹837 Data Errors Data Errors and Solutions Table››

‹‹837 Data Errors››	Solutions
Receiver ID not valid.	Verify file should be Medi-Cal and *Receiver ID* should be 610442. Correct the *Receiver ID* to fix.
Claim totals do not balance with claim records received.	Verify data on file for required segments, elements and sub elements or required record types.

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.