



HP Enterprise Services
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March 24, 2011

Dear Medical/Outpatient Providers,

Subject: Reprocess Lab Service Claims for Denials and Recovery

The Department of Health Care Services (DHCS) set a new policy with regard to the split bill percentages of select CPT-4 laboratory procedure codes. According to new policy effective February 1, 2010, selected laboratory codes were not split billable and could not be billed with modifiers ZS, TC or 26. The policy was subsequently changed on March 22, 2010. The prior policy was reinstated retroactively to February 1, 2010.

As a result of reinstating prior policy retroactively to February 1, 2010, including the automated recycled of claims that were in suspense status for (procedure code/modifier invalid) or claims awaiting *Resubmission Turnaround Documents* (RTDs) done by the Fiscal Intermediary in an effort to minimize the burden on the provider community, caused erroneous denials for both medical and outpatient claims processed between February 1, 2010 through March 21, 2010. Some of these claims were denied for the following denial reasons:

0090: The combination of service code and modifier is not valid

0196: The procedure requires a modifier, modifier is not present

9655: The provider needs to rebill with the appropriate diagnosis code or submit an appeal with the appropriate medical justification.

In addition to the erroneous denials, it also caused claims to be paid in error for same services when one claim paid without the modifier and the other with the modifier. Since prior policy was reinstated retroactively requiring the modifier, the paid claims without the modifier will result in a recovery in most cases.

No action is required on your part. HP Enterprise Services will be resubmitting and voiding the affected claims. The voids will appear on *Remittance Advice Details* (RAD) beginning the week of April 14, 2011, with RAD code **826: Claim void due to related claim(s) previously reimbursed**. Resubmits will appear on RADs beginning the week of April 21 2011, with Claim Control Number (CCN) prefix **109655**.

Not all claims denied for the RAD messages noted above are subject to reprocessing. Various scenarios require provider correction and/or appeal. Providers are reminded that the submitted claim must match the lab reservation. This includes the provider identifier, date of service, procedure code and modifier, among other data elements. In the event that the claim and the lab reservation do not match, the provider is expected to correct one or both, depending on the nature of the mismatch error. The lab reservation may be corrected by contacting the Telephone Service Center (TSC) at 1-800-541-5555, and an agent can make any necessary corrections. The claim and/or lab reservation may be corrected via the appeal process. Please refer to the *Appeal Form Completion* section in the Part 2 provider manual for further details.

This recovery is authorized under the provisions of *Welfare and Institutions Code* (W&I Code), Sections 14176 and 14177 and *California Code of Regulations* (CCR), Title 22, Section 51458.1(a)(1). In addition, the W&I Code sections authorize DHCS to enter into repayment agreements with providers or offset overpayments against amounts due. If your total warrant amount is not sufficient to offset the recovery, the negative balance will be converted to an accounts-receivable transaction and subtracted from future Medi-Cal payments.

Providers have three options to offset the negative accounts-receivable balance: 1) Send a check for the accounts-receivable balance to HP Cash Control. 2) Do nothing and allow the recovery process to withhold 100 percent of the weekly Medi-Cal checkwrite until the balance is paid in full. However, if the balance due is not recovered within 90 days, the account may be subject to collection. 3) Make repayment arrangements for a lower withhold percentage rate so that the balance due is recovered within 90 days of the Erroneous Payment Correction (EPC) implementation date. These arrangements can be made through the TSC at the number below.

If you disagree with any of these voids/resubmits, you may submit an appeal within 90 days of the void RAD date. Please refer to the *Appeal Form Completion* section in a Part 2 Medi-Cal provider manual or on the Medi-Cal website (www.medi-cal.ca.gov) for instructions about how to submit an appeal.

If you have any questions regarding this adjustment, please call the TSC at 1-800-541-5555, option 11, followed by option 17.

Sincerely,



Nona Carpenter
Provider Relations Director
Reference Number: P14376