Claims Follow-Up

Introduction

Purpose

The purpose of this module is to provide an overview of the options available to providers when following up on claims that have been submitted for payment.

Module Objectives

- Review timeliness standards
- Identify delay reason codes
- Understand Remittance Advice Details (RAD)
- Discuss the Resubmission Turnaround Document (RTD)
- Explain claim follow-up options for the Claims Inquiry Form (CIF), the Appeal form (90-1) and the Correspondence Specialist Unit (CSU)

Acronyms

A list of current acronyms is located in the Appendix section of each complete workbook.
Claim Follow-Up Description

A claim must be received within a specified time frame to process and adjudicate appropriately for payment or denial. The time frames are specific and need to be adhered to so that providers can receive timely reimbursement. Claims that have been improperly completed will be denied and providers will be notified via the RAD.

Claim Reimbursement Guidelines

Claim Submission Timeliness Requirements

Original Medi-Cal or California Children's Services (CCS) claims must be received by the California Medicaid Management Information System (California MMIS) Fiscal Intermediary within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit.
Full Reimbursement Policy

<table>
<thead>
<tr>
<th>Reimbursement Deadlines</th>
<th>Then claims must be received by the last day of this month:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the Date of Service (DOS) falls within this month:</td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>July</td>
</tr>
<tr>
<td>February</td>
<td>August</td>
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<tr>
<td>March</td>
<td>September</td>
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<td>April</td>
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<td>October</td>
<td>April</td>
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<tr>
<td>November</td>
<td>May</td>
</tr>
<tr>
<td>December</td>
<td>June</td>
</tr>
</tbody>
</table>

Partial Reimbursement Policy

Claims submitted after the six-month billing limit and received by the California MMIS Fiscal Intermediary without a valid delay reason will be reimbursed at a reduced rate according to the date in which the claim was received.

Partial reimbursement rates are paid as follows:

<table>
<thead>
<tr>
<th>0 MO.</th>
<th>2 MO.</th>
<th>3 MO.</th>
<th>4 MO.</th>
<th>5 MO.</th>
<th>6 MO.</th>
<th>7 MO.</th>
<th>8 MO.</th>
<th>9 MO.</th>
<th>10 MO.</th>
<th>11 MO.</th>
<th>12 MO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>75%</td>
<td></td>
<td></td>
<td>50%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reimbursement

Reimbursement

NOTES

__________________________________________
__________________________________________
__________________________________________
__________________________________________

March 2018
Delay Reason Codes

Claims can be billed beyond the six-month billing limit if a delay reason code is used. The delay reason code indicates that the claim form is being submitted after the six-month billing limit.

Although a delay reason code designates approved reasons for late claim submission, these exceptions also have time limits. Refer to the UB-04 Submission and Timeliness Instructions section (ub sub) or CMS-1500 Submission and Timeliness Instructions section (cms sub) in the Part 2 provider manual.

<table>
<thead>
<tr>
<th>Delay Reason Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Proof of Eligibility (POE) unknown or unavailable</td>
</tr>
<tr>
<td>3</td>
<td>TAR approval delays</td>
</tr>
<tr>
<td>4</td>
<td>Delay by DHCS in certifying providers</td>
</tr>
<tr>
<td>5</td>
<td>Delay in supplying billing forms</td>
</tr>
<tr>
<td>6</td>
<td>Delay in delivery of custom-made eye appliances</td>
</tr>
<tr>
<td>7</td>
<td>Third party processing delay</td>
</tr>
<tr>
<td>10</td>
<td>Administrative delay in prior approval process</td>
</tr>
<tr>
<td>11</td>
<td>Other (e.g. theft); attach documentation justifying the delay reason</td>
</tr>
<tr>
<td>15</td>
<td>Natural disaster</td>
</tr>
</tbody>
</table>

**NOTE**

To receive full payment, providers must attach documentation justifying the delay reason. Providers billing with delay reason code without the required attachments will be denied or reimbursed at a reduced rate.

**Billing Notice:** Most providers may no longer bill Medi-Cal or CCS using a recipient’s Social Security Number (SSN). Claims submitted with a recipient’s SSN will be denied.
Daily Reason Code Claim Form Examples

CMS-1500 Form
For the CMS-1500 form, enter a delay reason code in the unshaded area of the EMG field (Box 24C) when the claim is over the six-month billing limit. If an emergency code is listed in the unshaded area, place the delay reason code in the shaded area.

UB-04 Form
Place the delay reason code in unlabeled Box 37.

25-1 Form
Place the delay reason code in Billing Limits Exception field 11.
Claims Follow-Up

Claims Over One Year

Occasionally, a claim may be delayed more than one year past the date of service (DOS). The following is a list of possible scenarios that could result in a claim being submitted beyond one year:

- Third party decisions or appeals
- Determination of Medi-Cal eligibility
- Treatment Authorization Request (TAR) approval delay

Providers may still be eligible to receive 100 percent reimbursement of the Medi-Cal maximum allowable rate. Claims submitted more than 12 months after the month of service must use delay reason code 10. These claims must be billed hard copy and with appropriate attachments. Providers can send late claims to the California MMIS Fiscal Intermediary at the following address:

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

Claims submitted to the Over-One-Year Claims Unit must include a copy of the recipient’s proof of eligibility and may have additional documentation requirements.

Refer to the appropriate Part 2 provider manual section:

- UB-04 Submission and Timeliness Instructions (ub sub)
- CMS-1500 Submission and Timeliness Instructions (cms sub)

NOTE

- Claims and attachments more than a year old may not be submitted electronically.
- Claims more than a year old will not receive an acknowledgement or response letter.
- Providers will receive a RAD message indicating the status of their claim.

NOTES
Claim Follow-Up Process

Medi-Cal claims received by the California MMIS Fiscal Intermediary may not process through the California Medicaid Management Information System (CA-MMIS) as providers anticipate; sometimes claims are suspended or denied.

There are a number of reasons why claims do not process correctly. Some examples include:

- Minor information is omitted from the claim.
- Recipient information is incorrect.

CA-MMIS looks at claims critically in a series of edits and audits. After these edits and audits are complete, the claim is adjudicated or suspended.

Depending on the reason the claim was suspended or denied, the provider can take one of the following actions:

<table>
<thead>
<tr>
<th>If Claim was:</th>
<th>Provider Follow-up Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspended</td>
<td>Rebill the claim.</td>
</tr>
<tr>
<td></td>
<td>Return a <em>Resubmission Turnaround Document</em> (RTD).</td>
</tr>
<tr>
<td>Denied</td>
<td>Rebill the claim.</td>
</tr>
<tr>
<td></td>
<td>Submit a <em>Claims Inquiry Form</em> (CIF).</td>
</tr>
<tr>
<td></td>
<td>Submit an <em>Appeal form</em>.</td>
</tr>
<tr>
<td></td>
<td>Contact the Correspondence Specialist Unit (CSU).</td>
</tr>
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</table>

NOTES
Financial Reconciliation Statement – Remittance Advice Details (RAD)

RAD Description

The RAD is designed for line-by-line reconciliation of transactions. RADs offer providers a record to help determine which claims are paid, denied or not yet adjudicated. RADs are issued by the State Controller’s Office (SCO) and contain reimbursement data of claims being paid relevant to the payment period and a cumulative summary of year-to-date earnings.

If there are no claims being paid, or if a payment is being applied to a negative adjustment or Accounts Receivable (A/R), a No Payment Advice will be issued instead of a warrant.

Medi-Cal-only claims appear first, followed by Medicare/Medi-Cal crossover claims in the following sequence: adjustments, approvals, denials, suspensions and A/R transactions.

PDF RAD

Providers are able to securely view and download a PDF version of their paper RAD and a summary sheet called a Medi-Cal Financial Summary. The PDF RADs are available on the Medi-Cal website (www.medi-cal.ca.gov) under the Transaction Services tab.

PDF RAD Benefits

There are many benefits to accessing RAD and Medi-Cal Financial Summary information online:

- The PDF RAD (and embedded Medi-Cal Financial Summary information) are available before paper RADs and paper financial summaries.
- The PDF RAD and Medi-Cal Financial Summary contain all the information of paper RADs and paper financial summaries.
- There is no charge for this new online service.
- Up to six calendar weeks of current RADs are available for immediate download. In addition, a historical RAD database will be built. When complete, three years of historical RADs will be available within one business day of a request.
- Providers have the online ability to opt out of receiving paper RADs and help California go green.
- Printed versions of the online PDF RADs are adequate to submit as supporting documentation with Claims Inquiry Forms (CIFs) and Appeal forms.

No provider payments will be made via PDF RADs. PDF RADs are for informational purposes only.

Providers are encouraged to sign up for the ASC X12N 835 transaction using the Electronic Health Care Claim Payment/Advice Receiver Agreement form (DHCS 6246) available on the Forms page of the Medi-Cal website (www.medi-cal.ca.gov). For information about 835 transactions, providers may refer to “ASC X12N 835 Transaction” in the Remittance Advice Details (RAD): Electronic section (remit elect) in the Part 1 provider manual.
NOTE
To access Transaction Services, providers must have a signed Medi-Cal Point of Service (POS) Network/Internet Agreement form on file, a National Provider Identifier (NPI) and PIN. The Medi-Cal Point of Service (POS) Network/Internet Agreement form is available on the Forms page or through the “Transaction Enrollment Requirements” hyperlink on the Transaction Services tab of the Medi-Cal website (www.medi-cal.ca.gov).

Adjustments
Previously paid claims may be adjusted if an error in payment occurred. An adjustment may be initiated by the provider, the California MMIS Fiscal Intermediary or Department of Health Care Services (DHCS). An adjustment reprocesses a claim with corrected information and appears on the RAD as two lines.

- Line 1 – Shows the new Claim Control Number (CCN) and reflects the correct payment.
- Line 2 – Shows the original CCN and deducts the original payment.

A “void” adjustment appears on the RAD as a single line with a negative (-) amount. A void recovers the original payment without automatically reprocessing the claim. After a void is completed and the claim history is adjusted, providers may submit a new claim. This is a critical step. Sometimes providers void a claim and neglect to submit a new claim, and therefore do not receive payment.

Approvals
Approved claims are line items passing final adjudication. They may be reimbursed as submitted or at reduced amounts according to Medi-Cal program reimbursement specifications. Reduced payments are noted on the RAD with the corresponding RAD code.

NOTES
Denials
Denied claim lines represent claims that are unacceptable for payment due to one of the following conditions:

Claim information cannot be validated by the California MMIS Fiscal Intermediary.
- Billed service is not a program benefit
- Line item fails the edit/audit process
- Provider fails to return an RTD within the 60-day period

NOTE
A denied message on the RAD is the only record of a claim denial.

Suspensions
Claims requiring manual review of an RTD will temporarily suspend and appear on the RAD with a “suspend” message code. After a suspended claim has been in the claims processing system for more than 30 days, it will appear on the RAD until payment or denial.

NOTE
Providers should not submit a CIF for claims listed as “Suspended” on the most recent RAD because a CIF can only be processed on claims that have already been adjudicated.

NOTES
Accounts Receivable (A/R) Transactions

RADs may also reflect Accounts Receivable (A/R) transactions when necessary, either to recover funds from or pay funds to a provider. Claims that appear on the RAD are sorted by recipient name (alphabetical by last name of recipient and date of service). The Accounts Receivable system is used in financial transactions.

- A/R Transaction Types:
  - Recoupment of interim payments
  - Withholds against payments to providers according to State instructions
  - Payments to providers according to State instructions

- Unique Features:
  - A/R transactions are identified in the system by a 10-digit A/R transaction number, such as “1234567890.”
  - Amounts can be either positive (+) or negative (-) figures that correspond to the increase or decrease in the amount of the warrant.
  - A/R transaction codes appear at the bottom of the page in the RAD message column and begin with the number “7.”

Inquiries about A/R transactions should be mailed to the Cash Control Unit. Inquires must be submitted hard copy and include the A/R number and a copy of the RAD.

   Attn: Cash Control  
   California MMIS Fiscal Intermediary  
   P.O. Box 13029  
   Sacramento, CA 95813-4029
# Remittance Advice Details Form Example

![Remittance Advice Details Form Example](image)

**NOTE**
For additional information, refer to the Part 2 provider manual, *Remittance Advice Details (RAD) Examples: Allied Health and Medical Services* section (remit ex am).

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**Completed Sample Remittance Advice Details (RAD). Actual size is 8½ x 11 inches.**
Claim Control Numbers

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 California MMIS Fiscal Intermediary, and is used to monitor timely submission of a claim.

![Claim Control Number Diagram]

**CLM CONTROL NUMBER • FOR FI USE ONLY**

80 11 12 34 567 01

**JULIAN DATE**
(Date claims received)
January 11, 1998
(11th day of 1998)

**REEL NO.**

**BATCH NO.**

**CLAIM SEQUENCE NO.**

**HEADER/LINE NO.**

**ADJUDICATED**

**REEL NUMBERS:**

01-44, 48-49  Original Claim
45-47, 60-65  CMC
69, 71-74     CIF
82-89, 92     Crossover
98, 99        Appeals
NOTE

The Claim Control Number 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 California MMIS Fiscal Intermediary and is used to monitor timely submission of a claim.
For leap years, add one day to the number of days after February 28. Upcoming leap years include 2020 and 2024.

**Claim Follow-up Forms**

**Resubmission Turnaround Document (RTD)**

The RTD is used to notify providers when there is questionable or missing information on the claim. The RTD gives providers the opportunity to correct the claim before it is denied. Providers should return Section B (bottom portion) of the RTD to the California MMIS Fiscal Intermediary by the date indicated at the top of the RTD.

Providers have two options when they receive an RTD:

- Promptly complete and return Part B (the bottom portion of the RTD). A delay in returning the RTD may result in a claim denial.
- Submit a new claim, if timeliness permits.

The RTD should be mailed in a plain business envelope to the California MMIS Fiscal Intermediary at the following address:

California MMIS Fiscal Intermediary  
P.O. Box 15200  
Sacramento, CA 95851-1200

When the California MMIS Fiscal Intermediary receives the RTD, an operator keys in the corrections and the claim continues in the processing cycle.
RTD Form Example

RESUBMISSION TURNAROUND DOCUMENT

INSTRUCTIONS: Listed in Section "A" are error(s) found on the original claim. To expedite payment, type the correct information in the numbered Box of Section "B" that corresponds to numbered line in Section "A", sign and date the form, and return Section "B" (bottom portion) to F.I. Please respond promptly as the claim cannot be paid unless your corrections are received by October 31, 2007. See your provider manual for assistance regarding the completion of this form.

<table>
<thead>
<tr>
<th>INFORMATION BLOCK</th>
<th>SUBMITTED INFORMATION</th>
<th>SERVICE CODE</th>
<th>ERROR CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAR CONTROL NUMBER</td>
<td>A1123456789</td>
<td>0012</td>
<td>07/08/15</td>
</tr>
<tr>
<td>PROVIDER NUMBER</td>
<td>XXXXXXXXXXX</td>
<td>PROVIDER NAME</td>
<td>Smith, Mike</td>
</tr>
<tr>
<td>PROVIDER NAME AND ADDRESS</td>
<td>ABC PROVIDER</td>
<td>123 ANY STREET</td>
<td>ANYTOWN, CA 95000</td>
</tr>
<tr>
<td>PATIENT NAME</td>
<td>SMITH, MIKE</td>
<td>MED-CAL ID NUMBER</td>
<td>12345678A02009</td>
</tr>
<tr>
<td>MEDICAL RECORDS NO.</td>
<td>12345</td>
<td>TOTAL CHARGES</td>
<td>$1575.00</td>
</tr>
<tr>
<td>CLAIM CONTROL NUMBER</td>
<td>0170626097022</td>
<td>PROVIDER NUMBER</td>
<td>XXXXXXXXXXX</td>
</tr>
<tr>
<td>FINAL NOTICE DATE</td>
<td>August 30, 2015</td>
<td>PAGE</td>
<td>OF</td>
</tr>
<tr>
<td>SERVICE DATED</td>
<td>August 15, 2015</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DETACH AND RETURN TO APPROPRIATE F.I.

CORRESPONDENCE REFERENCE NUMBER - F.I. USE ONLY

RETURN THIS PORTION

This is to certify that the corrected information is true, accurate and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

Signature of provider or person authorized by provider

DATE

If specifically requested, place label in the box indicated below. This space may also be used for comments.

<table>
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<td>0012 - THE NUMBER GIVEN ON THE CLAIM AS THE TAR CONTROL NUMBER IS NOT NUMERIC OR HAS AN INCORRECT NUMBER OF DIGITS</td>
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</table>

CORRECT INFORMATION MUST BE ENTERED ON THE SAME LINE AS THE ERROR SHOWN IN SECTION "A".

PROVIDER NUMBER

F.I. USE ONLY

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Claims Inquiry Form (CIF)

The CIF is used to resolve claim payments or denials as identified on the RAD. There are four main reasons to submit a CIF:

- Trace a claim.
- Request reconsideration of a denied claim.
- Adjust an underpayment or overpayment of a claim.
- Request Share of Cost (SOC) reimbursement.

1. What went wrong with the claim?
2. What has the biller/provider done to correct the claim?
3. What do you want Medi-Cal/FI to do with the claim?
CIF Completion Instructions

CIF Completion Instruction Tips
1. Complete Provider Name/Address (Box 3), Provider Number (Box 4) and Claim Type (Box 5).
2. Complete the lines on the CIF according to the type of inquiry (for example, reconsideration of a denied claim; underpayment adjustment or overpayment adjustment).
3. Sign and date the bottom of the form and submit the signed, original copy of the CIF and all attachments to the California Medicaid Management Information System (California MMIS) Fiscal Intermediary. CIFs submitted without a signature will be returned to the provider.

Adjustments – Underpayment/Overpayment and Voids
A CIF adjustment should be used to correct both under and over payments. However, this transaction type is different than requesting a full payment recovery, which is a void.

CIF Adjustments – One-Step Process
If requesting an adjustment for an underpaid or overpaid claim, the adjustment is completed in one transaction, with the adjudication results appearing on a future RAD. The corrected CCN will appear as a credit and debit and be reflected on the same RAD.

Note: CIFs submitted for underpayments must be received within six months from the date of the RAD. CIFs received after six months on which the underpayment was indicated are subject to an automatic denial. A CIF void can be requested to fully recover or recoup monies paid. In many instances, the provider’s goal is to return funds. The CIF void process accomplishes this in one-step. However, if the provider wishes to void the original payment and submit a corrected claim, the CIF void is largely an automated process and cannot perform two functions; therefore, only the void can be processed.

CIF Adjustments – Two-Step Process
Providers requiring a void and subsequent resubmission of a corrected claim, use a two-step process. The CIF void must first be submitted to recoup the full payment. Once the void appears on a future RAD, the provider completes the second step by submitting an Appeal to request the processing of the corrected claim.

Note: The Appeal must be filed within 90 days from the date indicated on the RAD on which the void appeared and must include a copy of the corrected claim, a copy of the RAD that indicated the payment retraction and any other supporting documentation.

Reconsideration – To request reconsideration of a denied claim line after the six-month billing limit, attach a legible copy of the corrected original claim form, a copy of the RAD dated within six months of the denial date and all pertinent documentation.

Trace – Provider has no record of payment or denial of a previously submitted claim exists on the RAD and a provider wants to trace the status of a claim. Tracers may be submitted any time. However, the CIF processing system will only find information from the past 36 months of adjudicated claims. If a tracer is being used to prove timely submission of a claim, it must be received within the same six-month billing limit for claims.
Share of Cost (SOC) – SOC reimbursement requests are considered to be a form of adjustment. Claims Inquiry Forms (CIFs) submitted for Share of Cost reimbursement services require unique completion instructions. All SOC inquiries on a CIF must be for SOC reimbursement only.

CIFs should be submitted in black and white envelopes available from the California MMIS Fiscal Intermediary to the following address:

California MMIS Fiscal Intermediary
P.O. Box 15300
Sacramento, CA 95851-1300

Claims Inquiry Form Attachments
The following attachments are required for CIFs as they apply to the claim, except CIFs used as tracers or CIFs requesting SOC reimbursements:

- TAR indicating authorization
- “By Report” documentation
- Completed sterilization Consent Form (PM 330)
- Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)/National Standard Intermediary Remittance Advice (Medicare RA)
- Explanation of Benefits (EOB) from Other Health Coverage (OHC)
- Drugs and supplies itemization list, manufacturer’s invoice or description, including the name of the medication, dosages, strength and unit price
- Supplier’s invoice, indicating wholesale price and the item billed
- Manufacturer’s name, catalog (model) number and manufacturer’s catalog page, showing suggested retail price
- Copy of Point of Service (POS) device printout or Internet eligibility response attached to the claim on an 8 1/2 x 11-inch sheet of white paper

NOTE
All supporting documentation must be legible.

NOTES
Claims Inquiry Acknowledgement

Within 15 days of receipt, the California MMIS Fiscal Intermediary acknowledges requests for adjustments and reconsideration of denied claims with a Claims Inquiry Acknowledgement. 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 California MMIS Fiscal Intermediary does not respond after the initial CIF is filed, providers should file an appeal.

Sample: Claims Inquiry Acknowledgement

Status Numbers and Messages

<table>
<thead>
<tr>
<th>Status</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Accepted for resubmission of denied claim or underpayment/overpayment.</td>
</tr>
<tr>
<td>02</td>
<td>Accepted. Tracer status letter will be generated.</td>
</tr>
<tr>
<td>03</td>
<td>Rejected. Only one CCN per crossover CIF allowed.</td>
</tr>
</tbody>
</table>

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 in the response letter.
When Not To Use A CIF

- Incorrect provider number was used
- All claims denied for National Correct Coding Initiative (NCCI)
- Denied inpatient claims
- Suspended claims appearing on a current Remittance Advice Details (RAD) form
- Pharmacy Claims:
  - Compound Claims
  - POS network
  - RTIP
- The following RAD codes (Submit an Appeal)

<table>
<thead>
<tr>
<th>Code</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>0002</td>
<td>The recipient is not eligible for benefits under the Medi-Cal program or other special programs.</td>
</tr>
<tr>
<td>0010</td>
<td>This service is a duplicate of a previously paid claim.</td>
</tr>
<tr>
<td>0072</td>
<td>This service is included in another procedure code billed on the same date of service.</td>
</tr>
<tr>
<td>0095</td>
<td>This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.</td>
</tr>
<tr>
<td>0314</td>
<td>Recipient not eligible for the month of service billed.</td>
</tr>
<tr>
<td>0326</td>
<td>Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.</td>
</tr>
<tr>
<td>0525</td>
<td>NCCI (National Correct Coding Initiative) void of a column 2 claim previously paid when a column 1 claim has been processed for the same provider and date of service.</td>
</tr>
<tr>
<td>9940</td>
<td>NCCI (National Correct Coding Initiative) claim line is billed with multiple NCCI modifiers.</td>
</tr>
<tr>
<td>9941</td>
<td>NCCI (National Correct Coding Initiative) column 2 procedure code is not allowed when column 1 procedure has been paid.</td>
</tr>
<tr>
<td>9942</td>
<td>NCCI (National Correct Coding Initiative) quantity billed is greater than the allowed MUE (Medically Unlikely Edit) quantity.</td>
</tr>
</tbody>
</table>

NOTES

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

December 2017
## CIF Completion Tips

<table>
<thead>
<tr>
<th>CIF Completion Reminders</th>
<th>All Inquiries</th>
<th>Adjustments</th>
<th>Crossover, Inpatient and Pharmacy Compounds</th>
<th>Denial</th>
<th>SOC</th>
<th>Tracer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always enter an “X” in the box to indicate the claim type.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter no more than four claim inquiries per form.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NOTE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This does not apply to crossover and inpatient claims.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fill out each line completely. Do not use ditto marks (&quot;&quot; or draw an arrow to indicate repetitive information.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All information must be exactly the same as that on the RAD. For example, an incorrect ID number on the RAD should be copied exactly on the CIF.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only one claim line per CIF.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Be sure the recipient ID number and Claim Control Number on the CIF exactly match the numbers on the RAD.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RAD not required.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Enter the recipient's original ID (the number issued prior to being enrolled in a no-SOC program).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Do not use the <em>Remarks</em> area for additional inquiries.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State clearly and precisely what is being requested in the <em>Remarks</em> area.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always indicate the denial or adjustment reason code in the <em>Remarks</em> area.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secure documentation to the upper right-hand corner of the CIF.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do not attach any documentation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only original CIFs are accepted. Photocopies will be returned.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appeal Form

The appeal process offers Medi-Cal providers who are dissatisfied with the processing of a claim, the resubmission of a claim or CIF a method for resolving their dissatisfaction. An appeal must be submitted on an Appeal form (90-1). An Appeal form only allows a single recipient; therefore, a form must be completed for each individual.

Sample Appeal Form 90-1 Example
F Claims Follow-Up

Appeals should be mailed in the purple and white envelopes available from the California MMIS Fiscal Intermediary. Providers should send appeals to the California MMIS Fiscal Intermediary at the following address:

Attn: Appeals Unit  
California MMIS Fiscal Intermediary  
P.O. Box 15300  
Sacramento, CA 95851-1300

All supporting documentation must be legible. The following attachments as they apply to the claim are acceptable:

- Corrected claim, if necessary
- RADs pertaining to the claim history
- Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)
- Other Health Coverage (OHC) payments or denials
- All CIFs, Claims Inquiry Acknowledgements, Claims Inquiry Response letters or other dated correspondence to and from the California MMIS Fiscal Intermediary documenting timely follow-up
- Reports for “By Report” procedures
- Manufacturer’s invoice or catalog page
- Completed sterilization Consent Form (PM 330)
- Treatment Authorization Request (TAR) or Service Authorization Request (SAR)

The California MMIS Fiscal Intermediary will acknowledge appeals within 15 days of receipt and make a decision within 45 days of receipt. If a decision is not made within 45 days, the appeal is referred to the Professional Review Unit for an additional 30 days.

NOTES

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

24 March 2018
Appeal Form Completion Process

Complete the fields on the Appeal form according to the type of inquiry. Resubmission, underpayment and overpayment requests for the same recipient may be combined on one form.

<table>
<thead>
<tr>
<th>Appeal Form 90-1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fields</td>
<td>Instructions</td>
</tr>
<tr>
<td>3, 4, 5, 7, 8, 10, 11 and 12</td>
<td>These fields are required for all appeal types.</td>
</tr>
<tr>
<td>4, 5, 8 and 10</td>
<td>Provider Number, Claim Type, Patient’s Medi-Cal ID Number and Claim Control Number are completed to process an appeal. If these fields are left blank, providers may receive an appeal rejection letter requesting resubmission of a corrected Appeal form and all supporting documentation, proof of timely follow-up and submission.</td>
</tr>
</tbody>
</table>

**NOTE**
The correct recipient ID number must be entered in Box 8 (*Patient’s Medi-Cal ID No.*) even if the RAD reflects an incorrect recipient ID number.

Appeal Form Completion Tips

<table>
<thead>
<tr>
<th>Appeal Form Tips</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Appealing a Denial</td>
<td>If appealing a denial, enter the denial code from the RAD in Box 12.</td>
</tr>
<tr>
<td>Underpayment and Overpayment</td>
<td>If requesting reconsideration of an underpayment or overpayment, enter the payment code from the RAD in Box 12.</td>
</tr>
<tr>
<td>Adjustments</td>
<td>If requesting an adjustment, attach a legible copy of the original claim form, corrected if necessary, and a copy of the corresponding paid RAD. If requesting an overpayment adjustment because the patient named is not a provider's patient, attach only a copy of the paid RAD.</td>
</tr>
<tr>
<td>Signatures</td>
<td>Sign and date the bottom of the form. All appeals must be signed by the provider or an authorized representative. Appeals submitted without a signature will be returned to the provider.</td>
</tr>
</tbody>
</table>

**NOTES**
Correspondence Specialist Unit

The Correspondence Specialist Unit (CSU) resolves complex billing issues. TSC agents may refer you to the CSU for inquiries that require additional research.

Providers may write directly to CSU for clarification about recurring billing issues that have not been resolved through either the Claims Inquiry Form (CIF) or Appeal process and have resulted in claim denials. Correspondence Specialists respond to providers in writing to clarify billing procedures. Letters to CSU should be addressed to the California MMIS Fiscal Intermediary as follows:

   Attn: Correspondence Specialist Unit
   California MMIS Fiscal Intermediary
   P.O. Box 13029
   Sacramento, CA  95813-4029
Medi-Cal Provider Appeals Packet Checklist

Instructions: Before mailing an appeal to Medi-Cal please review this checklist and make sure you have all pertinent documents. Simply mark an ☒ next to all that apply.

☐ I have reviewed the Appeal Form Completion section in the Part 2 manual for Appeal form (90-1) completion instructions
☐ Medi-Cal Appeal form (90-1) complete
☐ If appeal is for a claim that may be an underpayment or overpayment, then enter payment code found on the RAD in Box 12
☐ If appeal is for claim denial then enter the denial code from the RAD in Box 12 on Form (90-1)
☐ For an overpayment adjustment because the patient named is not the provider’s patient, then attach only a copy of the paid RAD to Appeal form (90-1)
☐ Copy of original claim
☐ Remittance Advice Details
☐ Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)
☐ Treatment Authorization Request (TAR) or Service Authorization Request (SAR)
☐ Health coverage payments or denials
☐ Claims Inquiry Form
☐ Claims Inquiry Acknowledgements
☐ Claims Inquiry Response letters
☐ All dated correspondence sent to Medi-Cal
☐ All dated correspondence received from Medi-Cal documenting timely follow-up (must be on California MMIS Fiscal Intermediary letterhead)
☐ Reports for “By Report” procedures
☐ Manufacturer’s invoice or catalog page
☐ Lab reports showing different times or sites for multiple procedures
☐ If appeal is for a claim that bills for twins, ensure each twin (Twin A or Twin B) is correctly indicated on the claim in the Patient’s Name field (Box 2)
☐ Attach proof of recipient eligibility if date of service (DOS) is over 15 months or last denial was for eligibility
☐ Completed sterilization Consent Form (PM 330)
☐ I have signed and dated the bottom of Appeal form (90-1) (All appeals must be signed by the provider or an authorized representative for the provider. Appeals submitted without a signature will be returned to the provider)
Resource Information

References

The following reference materials provide Medi-Cal claim information.

Provider Manual References

Part 1
Claim Submission and Timeliness Overview (claim sub)

Part 2
Appeal Form Completion (appeal form)
CIF Completion (cif co)
CIF Submission and Timeliness Instructions (cif sub)
CMS-1500 Completion (cms comp)
CMS-1500 Submission and Timeliness (cms sub)
Remittance Advice Details (RAD) (remit adv)
Resubmission Turnaround Document (RTD) Completion (resub comp)
UB-04 Completion: Outpatient Services (ub comp ob)
UB-04 Submission and Timeliness (ub sub)

Resource Tools

<table>
<thead>
<tr>
<th>Medi-Cal Website</th>
<th>Telephone Service Center (TSC)</th>
<th>Regional Representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.medi-cal.ca.gov">www.medi-cal.ca.gov</a></td>
<td>1-800-541-5555</td>
<td>Call TSC and ask for a Regional Representative to visit your office</td>
</tr>
</tbody>
</table>