CIF Overview

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The *Claims Inquiry Form* (CIF) is used after submitting a claim to request one of the following:

- Adjustment – A claim has been paid at a different amount from the expected Medi-Cal maximum allowable and a provider requests an adjustment for underpayment, overpayment or reimbursement for Share of Cost.
- Reconsideration – A claim has been denied and a provider has information that would correct the reason for denial.
- Tracer – No record of payment or denial of a previously submitted claim exists on the Remittance Advice Details (RAD) and a provider wants to trace the status of a claim. The California MMIS Fiscal Intermediary inquires into the payment records and sends a letter to the listed provider stating whether or not there is a record of a claim as specified on the CIF. If a record is found, the letter specifies the FI's action on the claim; for example, date of payment or date of denial. If a tracer is used to process timely submission and there is no record of receipt of the claim, providers may file an appeal with copies of supporting documentation (refer to the *Appeal Process Overview* section in this manual).

  Note: Providers may not use CIFs in connection with claims denied as a result of National Correct Coding Initiative (NCCI) edits. Providers must submit an appeal. Refer to the *Correct Coding Initiative: National* section in the appropriate Part 2 manual.

Refer to the *CIF Completion* section in the Part 2 manual for CIF completion instructions.

‹‹Electronic Claim Resubmission May Avoid CIF

Before preparing a paper CIF for a claim adjustment or reconsideration, providers may want to determine if their claim issue might be resolved by electronically voiding and resubmitting the claim. Information about claim voids and resubmission is available in the Part 1, *Electronic Methods for Eligibility Transactions and Claim Submissions* provider manual section under the heading, "Electronic Claims Resubmissions/Voids: 837I and 837P." Electronic claim resubmission is not available for pharmacy claims.››

Timeliness

CIFs must be submitted according to the following timelines. (See *California Code of Regulations*, Title 22, Section 51008[d].)

Adjustments

Adjustment requests for underpayments must be submitted within six months following the date of payment on a RAD. Requests for overpayment adjustments may be submitted any time.

Reconsideration of Denied Claims

Requests for reconsideration of denied claims must be submitted within six months following the date of denial on a RAD. However, submitting a new claim within the original six-month billing limit may be a faster process.

Tracers

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.

Suspended Claims

Providers should not submit a CIF for a claim appearing as suspended on a current RAD.

Where to Submit CIFs

Providers should mail CIFs to the FI:

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

Acknowledgement and CIF Processing

Within 15 days of receipt, the FI will acknowledge requests for adjustments (including overpayment returns) 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. If the claim submitted with the initial CIF does not appear on a RAD and a *Claims Inquiry Response Letter* is not received, a provider may file an appeal.

Review of CIF

For adjustments and reconsideration requests, the FI takes the information found in the inquiry and an examiner reviews all the information presented, both in the computer inquiry and in the attachments to the CIF and processes the new claim according to Medi-Cal policy. It is important that the information entered on the CIF exactly matches what is displayed on the RAD, even if that information is wrong. This enables the FI to find the claim in history files.

Claims Inquiry Response Letter

For tracers, a *Claims Inquiry Response Letter* is prepared detailing the findings of that inquiry. The FI enters the information presented on the CIF into the paid claims history files and matches the information to what happened previously with the claim. It is important that the information entered on the CIF exactly matches what was submitted on the claim, even if that information is wrong.

Filing an Appeal

Providers who want to pursue further action may file a formal appeal. Refer to the *Appeal Process Overview* section in this manual for more information.

‹‹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.