Payment Request for Long Term Care (25-1): Submission and Timeliness Instructions

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This section provides procedures and guidelines for claim submission and timeliness. For specific claim completion instructions, refer to the *Payment Request for Long Term Care (25-1) Completion* section in this manual.

Where to Submit Claims

‹‹Submit paper claims to the California Medicaid Management Information System (MMIS) Fiscal Intermediary (FI) at the following address:››

California MMIS Fiscal Intermediary
P.O. Box 15400
Sacramento, CA 95851-1400

Six-Month Billing Limit

‹‹Original (or initial) Medi-Cal claims must be received by the California MMIS 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›› on a following page in this section 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 delay reasons:

- Enter the appropriate delay reason code (1, 3 thru 7, 10, 11 or 15) in the *Delay Reasons* field of the claim.
- Complete the *Explanations* field of the claim with the information required for delay reason codes 1 (description 1) and 3 thru 6.
- Attach substantiating documentation to justify late submittal of the claim for delay reason codes 1 (description 2), 7, 10, 11 and 15. ‹‹The *Delay Reasons* table on the following pages describes the documentation required for each billing limit exception.››

Note: Delay reason codes 1 (description 2), 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 may be billed electronically using the ASC X12N 837 v.5010 Institutional claim format with a *Medi-Cal Claim Attachment Control Form* (ACF). For more information regarding attachment submissions, refer to the “Computer Media Claims” information in the *Electronic Methods for Eligibility Transactions and Claim Submission* section in the Part 1 provider manual.

Providers who do not meet any delay reasons when submitting claims during the seventh through twelfth month after the month of service should enter an “11” in the *Delay Reasons* field 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) signed by an official of the county, 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) signed by an official of the county, 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) signed by an official of the county, or Copy of the original county-generated *Notification of Eligibility for Letter of Authorization*››
County error	10	‹‹Copy of the original *Eligibility Letter of Authorization* (LOA) form (MC 180/ MC 180-2) signed by an official of the county, 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**››
Department of Health Care Services (DHCS) approval	10	‹‹Copy of the original *Eligibility Letter of Authorization* (LOA) form (MC 180/ MC 180-2) signed by an official of the county, or Copy of the original county-generated *Notification of Eligibility for Letter of Authorization*››
Reversal of decision on appealed TAR	10	Copy of the TAR, copy of the DHCS letter or court order reversing the TAR denial, and on explanation of the circumstances in the *Explanations* area
Medicare/Other Coverage Health Coverage	10	Copy of Other Health Coverage Explanation of Benefits and an explanation of the circumstances in *Explanations* area

‹‹**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 in this manual for more information.

‹‹**Table 2: Delay Reasons**››

Reason Code	Description	Documentation Needed
1	(1) ° Proof of eligibility unknown or unavailable.	(1) In the *Explanations* area, enter month, day, and year when proof of eligibility (or retroactive eligibility) was received, for example, "Proof of eligibility received April 8, 2002."
1	(2) ‡ For Share of Cost reimbursement processing.	(2) Attach a Share of Cost Medi-Cal Provider Letter (MC 1054) for SOC reimbursement processing.
3 *	TAR approval days	In the *Explanations* area enter only the approval date of the TAR or California Children's Services (CCS) authorization.
4 *	Delay by DHCS in certifying providers.	In the *Explanation*s area, enter a statement indicating the date of certification.
5 *	Delay in supplying billing forms.	In the *Explanations* area, enter a statement indicating the date billing forms were requested and date received.
6 *	Delay in delivery of custom-made eye appliances.	In the *Explanation*s area, enter a statement explaining why the appliance was not previously delivered to the recipient.
7 * + ‡	Third party processing delay. (1) Medicare/Other Health Coverage.	With the Medi-Cal claim, submit a copy of the Other Health Coverage Explanation of Benefits or Remittance Advice showing payment or denial.
7 * + ‡	(2) ♣ Charpentier rebill claims.	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.	Submit recipient proof of eligibility and the court order or fair hearing decision.
10 ± ‡	(1) Decisions/appeals.	‹‹None››
10 ± ‡	(2) Delay or error in the certification or determination of Medi-Cal eligibility	‹‹Submit a copy of the original *Eligibility Letter of Authorization* (LOA) form (MC 180/ MC 180-2) signed by an official of the county (In the *Explanations* area, indicate date received from the recipient), or Copy of the original county-generated Notification of Eligibility for Letter of Authorization››
10 ± ‡	(3) Update of a TAR beyond the 12-month limit.	Submit recipient proof of eligibility and copy of the updated TAR.
10 ± ‡	(4) Circumstances beyond the provider's control as determined by DCHS.	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).	Attach documentation justifying the delay reason.
11	Other (2) † After six months, no reason.	None
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.

Refer to the *Code Correlation Guide* at the end of the *Payment Request for Long Term Care (25-1) Completion* section in this manual for information about whether to bill with national delay reason codes or local Medi-Cal billing limit exception codes.

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 CA-MMIS FI no later than one year from the month of service.
§	Claims related to these circumstances must be received by the DHCS; CA-MMIS 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, together with the Medicare or Other Health Coverage Explanation of Benefits/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 CA-MMIS FI within 60 days of the other health carrier's resolution (payment/denial).
±	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.
‡	May be billed hard copy using a Payment Request for Long Term Care (25-1) claim form, or electronically, using the ASC X12N 837 v.5010 Institutional claim format with a *Medi-Cal Claim Attachment Control Form* (ACF).
†	Claims related to these circumstances will be reimbursed at a reduced rate according to the date the claim was received by the CA-MMIS FI. Refer to "Reimbursement for Late Claims" in the *Claim Submission and Timeliness* section in the Part 1 manual.
♣	Charpentier rebill claims must be received within six months of Medi-Cal RAD date for the original crossover claim.
°	Claims related to this circumstance must be received by the CA-MMIS FI 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.