Pharmacy Claim Form (30-1) 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 *Pharmacy Claim Form (30-1) Completion* section of this manual.

Where to Submit Claims

Submit paper claims to:

California MMIS Fiscal Intermediary
P.O. Box 15700
Sacramento, CA 95852-1700

Six-Month Billing Limit

Original (or initial) Medi-Cal claims must be received by the 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. For example, if services are provided on April 15, the claim must be received by the CA-MMIS FI prior to October 31 to avoid payment reduction or denial for late billing.

Billing Limit Exceptions

Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the billing limit exceptions allowed by regulations. Billing limit exceptions also have time limits. See ‹‹*Table 2*›› for a list of billing limit exception codes and required documentation.

Late Billing Instructions

Follow the steps below to bill a late claim that meets one of the approved exception reasons:

- Enter the appropriate billing limit exception reason code (1 through 8 or "A") in the *Billing Limit Exception* field (Box 75) of the claim.
- Complete the *Specific Details/Remarks* area with the information required for reason codes 1 (descriptions 1 and 2) and 3 thru 5.
- Attach substantiating documentation to justify late submittal of the claim for reason codes 1 (description 2), 2 and 6 thru 8. The *Billing Limit Exceptions* charts on following pages describe the documentation required for each billing exception.

Note: Claims with billing limit exception codes may not be billed electronically since the electronic billing format does not support billing limit exception codes. Claims requiring billing limit exception codes and supporting attachments must be hard copy billed.

Providers who do not meet any billing limit exception reasons when submitting claims during the seventh through twelfth month after the month of service should enter an "A" in the *Billing Limit Exception* field (Box 75) of the claim.

Claims Over One Year Old

The CA-MMIS FI 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 *Figure 1* 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.

‹‹Table1: Documentation Needed for Over-One-Year Claims››

Cause of Delay	Billing Limit Exception Code	Documentation Needed
Retroactive SSI/SSP	10	Copy of the original *County Letter Authorization* (LOA) form (MC-180) signed by an official of the county
Court order	10	Copy of the original *County Letter Authorization* (LOA) form (MC-180) signed by an official of the county
State or administrative hearing	10	Copy of the original *County Letter Authorization* (LOA) form (MC-180) signed by an official of the county
County error	10	Copy of the original *County Letter Authorization* (LOA) form (MC-180) signed by an official of the county
Department of Health Care Services (DHCS) approval	10	Copy of the original *County Letter Authorization* (LOA) form (MC-180) signed by an official of the county
Reversal of decision on appealed *Treatment Authorization Request* (TAR)	10	Copy of the TAR, copy of DHCS letter or court order reversing the TAR denial, and an explanation of the circumstances in the *Specific Details/Remarks* area
Medicare/Other Health Coverage	10	Copy of the Other Health Coverage *Explanation of Benefits* and an explanation of the circumstances in *Specific Details/Remarks* 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 of this manual for more information.

‹‹Table 2: Billing Limit Exceptions››

Reason Code	Description	Documentation Needed
1	(1)* Proof of eligibility unknown or unavailable; includes retroactive eligibility or ID cards, if applicable.	In the *Specific Details/Remarks* area, enter month, day, and year when proof of eligibility was received, for example, "Proof of eligibility received March 15, 2006."
1	(2) For Share of Cost (SOC) reimbursement processing.	Attach a Share of Cost Medi-Cal Provider Letter (MC 1054) for SOC reimbursement processing.
2§‡	(1) Other Health Coverage, including Medicare, Kaiser, CHAMPUS and other health insurance.	With the Medi-Cal claim, submit a copy of the Other Health Coverage *Explanation of Benefits* or *Remittance Advice Details* (RAD) showing payment or denial.
2§‡	(2) Charpentier rebill claims.&	Submit a copy of the *Remittance Advice Details* (RAD) for the original crossover claim.
3§	Authorization delays in TAR approval.	In the *Specific Details/Remarks* area, enter only the approval date of the TAR or CCS authorization.
4§	Delay by DHCS in certifying providers or by the CA-MMIS FI in supplying billing forms.	In the *Specific Details/Remarks* area, enter a statement indicating the date of certification and/or the date billing forms were requested and date received.

‹‹Table 2: Billing Limit Exceptions (continued)››

Reason Code	Description	Documentation Needed
5§	Delay in delivery of custom-made eye, prosthetic or orthotic appliances.	In the *Specific Details/Remarks* area, enter a statement explaining why the appliance was not previously delivered to the recipient.
6§	Substantial damage by fire, flood or disaster to provider records.	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.
7Ω	Theft, sabotage or other willful acts by an employee. **Note:** Negligence by an employee is <u>not</u> covered by this reason code.	Attach a letter on provider letterhead documenting the incident and the date the incident was reported to a law enforcement agency. The letter must be signed by the provider or provider's designee.
10¥	(1) Court order or State or administrative fair hearing decision.	Submit recipient proof of eligibility and the court order or fair hearing decision.
10¥	(2) Delay or error in the certification or determination of Medi-Cal eligibility.	Submit a copy of the original LOA form (MC-180) signed by an official of the county. In the *Specific Details/Remarks* area, indicate date received from the recipient.
10¥	(3) Update of a TAR beyond the 12-month limit.	Submit recipient proof of eligibility and copy of the updated TAR.

‹‹Table 2: Billing Limit Exceptions (continued)››

Reason Code	Description	Documentation Needed
10¥	(4) Circumstances beyond the provider's control as determined by DHCS.	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 12 months from the month of service.
A†	Claims submitted after the six-month billing limit and received by the CA-MMIS FI during the seventh through twelfth month after the month of service and none of the exceptions above apply.	None.

‹‹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 will be reimbursed at a reduced rate according to the date the claim was received by the CA-MMIS FI. Refer to "Late Claims" on a previous page for information about these reductions.
*	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.
‡	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).
&	Charpentier rebill claims must be received within six months of Medi-Cal RAD date for the original crossover claim.
§	Claims related to these circumstances must be received by the CA-MMIS FI no later than one year from the month of service.
Ω	Claims related to these circumstances must be received by DHCS, CA-MMIS Division, Provider Services Section, MS 4716, 830 Stillwater Road, West Sacramento, CA 95605 no later than one year from the date of service.
¥	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.