
Provider Billing after Beneficiary Reimbursement (Conlan v. Shewry)

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This section includes claims processing guidelines for providers submitting claims covered by the terms of the Conlan v. Shewry court ordered Beneficiary Reimbursement process. These guidelines apply to all Medi-Cal provider types.

Background

The Beneficiary Reimbursement process provides that eligible beneficiaries who paid out-of-pocket for medical or dental care either during the three month retro period prior to the month they applied for Medi-Cal eligibility, or while waiting for their Medi-Cal applications to be approved, or after receiving their Medi-Cal card are entitled to be reimbursed for out-of-pocket monies they paid to a provider for Medi-Cal covered services. In general, beneficiaries are notified by letter that they may qualify for reimbursement under the terms of the court order.

Beneficiary Service Center

A Beneficiary Service Center (BSC) was established to work with both providers and beneficiaries to process Beneficiary Reimbursement claims. Beneficiaries may contact the center to obtain information and forms for requesting reimbursement. The BSC address and telephone number are as follows:

Beneficiary Service Center
P.O. Box 138008
Sacramento, CA 95813-8008
Phone: (916) 403-2007

BSC Responsibilities

BSC responsibilities include the following:

- Verifying beneficiary Medi-Cal eligibility
- Verifying the service was a Medi-Cal covered benefit on the date of service
- Evaluating supporting medical expense documentation provided by the beneficiary
- Reviewing rendered services for medical necessity
- Determining whether Medi-Cal payment was previously made
- Verifying that the provider reimbursed the beneficiary
- Maintaining documentation for each case

Provider Notification of Beneficiary Request for Reimbursement

If a beneficiary's request for reimbursement is validated by the BSC, a letter of request for beneficiary reimbursement is sent to the provider. The letter, *Letter 08*, must be submitted with the provider's claim for reimbursement.

Provider Responsibility

Providers, upon receipt of the beneficiary reimbursement letter (*Letter 08*), are expected to reimburse beneficiaries for monies the beneficiary paid to the provider for a Medi-Cal covered service, then bill Medi-Cal for the same service. Claims will be denied if the beneficiary has not been reimbursed. In accordance with the court order to obtain prompt reimbursement to the beneficiary, providers that do not comply with the request for beneficiary reimbursement are subject, when appropriate, to recoupment action by the Department of Health Care Services (DHCS) of all monies paid to the provider by the beneficiary for Medi-Cal covered services.

Claim Submission

Providers must, within 60 days of the date on the beneficiary reimbursement letter, submit claims to Medi-Cal as follows:

- Submit an original hard copy claim solely for services mentioned in the beneficiary reimbursement letter
- Enter delay reason code 10 in the appropriate claim field (refer to instructions in the *Claim Submission and Timeliness Overview* section of the Part 1 manual)
- Attach the beneficiary reimbursement letter
- Attach any additional required Medi-Cal documentation

The original claim, beneficiary reimbursement letter and supporting documentation must be submitted to the California MMIS Fiscal Intermediary at the following address:

California MMIS Fiscal Intermediary
Beneficiary Service Center Claims Unit
P.O. Box 138008
Sacramento, CA 95813-8008

No electronic claim submission is allowed. Because the BSC determines medical necessity, no *Treatment Authorization Request (TAR)* is required. The six-month billing limit will be modified for these claims.

Appeal Process Overview

Filing an Appeal

Appeals filed on claims resulting from a beneficiary request for reimbursement will follow the same guidelines referenced in the *Appeal Form Completion* section of this manual.

Refer to the *Appeal Form Completion* section of the Part 2 manual for *Appeal Form (90-1)* completion instructions.

Timeliness: 90-Day Deadline

Providers must submit an *Appeal Form* in writing within 90 days of the action/inaction precipitating the complaint. Failure to submit an appeal within this 90-day time period will result in the appeal being denied. See *California Code of Regulations*, Title 22, Section 51015.

Where to Submit Appeals

Providers should mail appeals to the FI at the following address:

California MMIS Fiscal Intermediary
Beneficiary Service Center Claims Unit
P. O. Box 138008
Sacramento, CA 95813-8008

Claims Inquiry Forms (CIFs)

Claims Inquiry Forms (CIFs) will not be accepted on providers' claims resulting from a beneficiary request for reimbursement.

For reconsideration of a denied claim, an appeal must be filed.

Reimbursement

The reimbursement rate is the rate on file for the date of service, or if one is not listed, the current rate.

Enrollment Requirement

To be reimbursed, the provider must have been enrolled as a Medi-Cal provider on the date of service. Per the instructions on the beneficiary reimbursement letter, providers should contact the Medi-Cal Provider Enrollment Branch if any of the following conditions apply:

- The provider was not a Medi-Cal provider on the date of service, but wants to enroll now.
- The provider is a Medi-Cal provider now, but was not on the date of service and needs retroactive eligibility.
- The provider was not a Medi-Cal provider on the date of service, but wants to temporarily enroll retroactively in Medi-Cal in order to bill for the Beneficiary Reimbursement Process claims.

Claims for Medi-Cal Managed Care Beneficiaries

Providers must verify eligibility for Medi-Cal managed care beneficiaries and seek prior authorization from the Medi-Cal managed care plan before rendering non-emergency services. Providers risk denials of claims for services if they are not members of the provider network of the managed care plan in which the beneficiary is enrolled.

<<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.