DHCS
SANDRA SHEWRY
Director

State of California—Health and Human Services Agency
Department of Health Care Services


ARNOLD SCHWARZENEGGER
Governor

Date: April 16, 2008

MMCD POLICY LETTER 08-002

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: PAYMENT OF INVOICES BEYOND THE SIX-MONTH BILLING LIMIT

Purpose

The purpose of this letter is to provide clarification regarding the 6-month billing limit set forth in Medi-Cal Managed Care Division (MMCD) Policy Letter 98-11, entitled *Family Planning Services in Medi-Cal Managed Care,* dated December 28, 1998. This clarification is not limited to family planning services and shall apply to all claims submitted by providers to managed care plans.

Background

In MMCD Policy Letter 98-11, the last sentence of paragraph seven, under Reimbursement of the Policy section (page 3), asserts that Medi-Cal managed care plans are not responsible for reimbursing out-of-plan provider claims received more than six months from the date of service. Furthermore, the last sentence in paragraph six, under Reimbursement of the Discussion section (page 9), provides that out-of-plan providers are not to submit claims for service more than six months from the date of service. Both sentences need to be clarified to ensure compliance with Welfare and Institutions (W&I) Code, Section 14115, and the California Code of Regulations, Title 22, Sections 51008 and 51008.5, which allow for submittal exceptions beyond the six-month billing limit for all claims submitted by providers to managed care plans, including claims for Family Planning Services.

W&I Code Section 14115 sets forth the statutory authority requiring bills for Medi-Cal services to be submitted for payment within six months of the month of service. This requirement is referred to as the six-month billing limit. In addition, Section 14115 allows for the following four exceptions to the six-month billing limit:

1. Failure of the patient to identify himself or herself as a Medi-Cal beneficiary within four months after the month of service.

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2. If a provider has submitted a bill to a liable third party, the provider has one year after the month of service to submit the bill for payment.

3. If a legal proceeding has commenced in which the provider is attempting to obtain payment from a third party, the provider has one year to submit the bill after the month in which the services have been rendered.

4. The director finds that the delay in submission of the bill was caused by circumstances beyond the control of the provider.

Pursuant to Title 22, Section 51008, except for good cause, bills must be submitted no later than six months following the month of service. Good cause is defined in this section as circumstances beyond the control of the provider. In Title 22, Section 51008.5 (a), the four exceptions noted in W&I Code Section 14115 are also noted as the four circumstances that justify good cause for the late submittal of a claim.

Policy

All Medi-Cal managed care plans are contractually responsible for having established policies and procedures to ensure the proper processing of claims. These policies and procedures must be in compliance with W&I Code Section 14115 and Title 22, Sections 51008 and 51008.5, which allow providers to submit a Medi-Cal claim for payment beyond the 6-month billing limit in specified situations.

Should you have any questions or require additional information regarding the content of this policy letter, please contact Christina Rodriguez-Moreno, Chief of the Policy and Contracts Section, at (916)449-5039 or via email at Christina.RodriguezMoreno@dhcs.ca.gov.

Sincerely,

Vanessa M. Baird, MPPA, Chief
Medi-Cal Managed Care Division