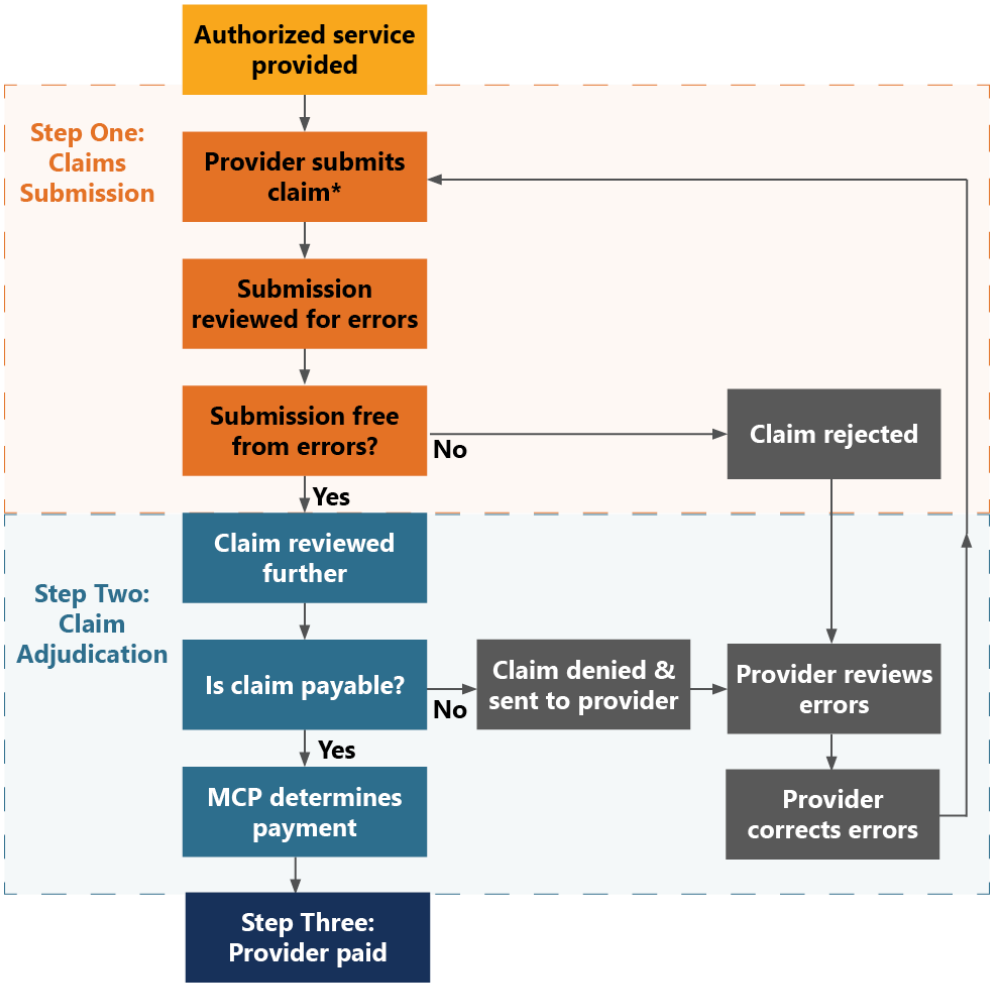
MEDI-CAL MANAGED CARE BILLING AND PAYMENT FOR LONG-TERM CARE PROVIDERS

This resource for long-term care (LTC) providers explains the Medi-Cal managed care billing process, covering common challenges and providing tips for streamlining practices.

Medi-Cal Managed Care Billing Process

Understanding the steps of the billing process in managed care is crucial for ensuring receipt of timely and accurate reimbursement. The chart below provides an overview of the managed care billing process, with explanations and tips.



**To a clearinghouse or to the managed care plan (MCP).*

Step One: Claims Submission

Submitting claims correctly is the first step in ensuring timely reimbursement and consistent operations. The LTC provider's contract or provider agreement with each MCP outlines the process for submitting claims.[1],[2]

Electronic claims are typically sent to a clearinghouse, which checks for errors. A "clean claim" is error-free and can proceed without needing additional information from the LTC provider. MCPs are required to ensure providers are trained to use electronic systems to facilitate the timely payment of clean claims.

If there are errors, the claim is rejected and returned to the provider to correct and resubmit. Claims are typically rejected due to discrepancies with MCP records or noncompliance with Medi-Cal billing rules and MCP billing standards. Here are common reasons for claim rejections and tips to avoid them:

Questions to ask MCPs

- What is your policy on timely filing?
- Where are your clean claim billing instructions and requirements?
- How should I submit claims? What is the preferred method of claims submissions?
- Which clearinghouses do you accept?
- Where can I find resources to assist me with submitting claims?
- Outside of the MCP long-term services and support (LTSS) liaison, who else can I reach out to for help?

Common Issues & Tips

- **Submitting a claim late.** Always check each MCP's claim filing deadlines. Even clean claims submitted late can be denied.
- **Submitting duplicate claims.** Check the claim status before resubmitting. If a claim is denied or partially paid, submit an appeal instead of resubmitting.
- **Incomplete or inaccurate provider information.** Ensure billing provider information is complete and correct, including National Provider Identifier (NPI), Tax Identification Number, name, phone number, and address. The taxonomy code, a NPI related unique identifier used to classify providers, although not

[1] *Intermediate Care Facilities for the Developmentally Disabled Homes may submit invoices with the UB-04 information and elements as specified in CalAIM Data Guidance Version 1.1.*

[2] *Effective February 1, 2024, DHCS transitioned to National Uniform Billing Committee (NUBC) data elements and national claim form for Medi-Cal fee-for-service (FFS). More information about the conversion can be found on the DHCS LTC Claim Form and Code Conversion webpage. Because MCPs are not required to align billing codes with Medi-Cal FFS, providers are encouraged to validate billing codes with MCPs.*

required may help MCPs identify providers. The rendering provider's name, phone number, and address are also required.

- **Incomplete or inaccurate member information.** Prior to rendering services, verify that the member information is complete and correct including Medi-Cal eligibility and MCP enrollment. One way to verify this it to check the member's Medi-Cal Benefits Identification Card (BIC) for a current issue date of one year or less, or check the Automated Eligibility Verification System (AEVS).
- **Incomplete or incorrect billing codes**. Even though Medi-Cal moved to using NUBC for LTC claims, each MCP may require a different set of billing codes depending on the LTC benefit and distinct services. Verify the accepted billing codes for each MCP, and stay updated on their requirements by reviewing newsletters, billing guidance, and training. Providers should refer to the process outlined in their MCP contract or provider agreement on how to escalate any billing code concerns or issues. Providers may also reach out to the MCP LTSS Liaison with any additional billing code questions or concerns.
- **Failing to identify other insurances.** Report any other insurance the member has, and ensure it is included in the claim. For more information about LTC crossover billing policy, refer to All Plan Letter (APL) 13-003.
- **Failing to account for member payment obligations.** Report Share of Cost (SOC) payments and other payment obligations on the claim. LTC providers are responsible for collecting SOC payments and reporting it to the MCP. For more information, refer to the Share of Cost section in the MCP Provider Manual and the provider portal.

Additional Resources

The following resources outline the FFS claims submission process and can help LTC providers understand required data and other aspects of the claims submission process. However, LTC providers should always refer to the current billing protocols and processes of each MCP they work with as the primary source of billing information.

- Long-Term Care Medi-Cal Provider Training Manual 2024
- UB-04 Completion: Long-Term Care section of the Provider Manual

Step Two: Claims Adjudication

After a claim is submitted and passes the initial review for billing errors, the MCP will review it to ensure proper authorization. If the claim is approved, the MCP applies the reimbursement rate and any applicable patient cost-sharing to determine the final payment. If the claim is not payable, the MCP will deny the claim. LTC providers should refer to the MCP billing guidance or their contract with the MCP for questions about the adjudication process.

Questions to ask MCPs

- How can I track the status of my claims?
- If you have a provider portal or a similar mechanism, how can I get access?
- What is the typical time of claims adjudication?
- Is there an expedited process for urgent claims?
- What information is verified during adjudication?

Step Three: Payment

After adjudication, if the MCP owes a payment to the LTC provider, it will be sent in the provider's preferred manner. MCPs cannot provide payments in the form of gift cards. The MCP will also send remittance advice to the provider that includes payment information and reason codes explaining any adjustments or denials. Refer to APL 23-020 for MCP requirements on paying claims timely.

Electronic Funds Transfers

LTC providers can receive payments by electronic funds transfers (EFT) if they submit claims electronically. EFTs send health care payments from an MCP to a provider's bank. To set up EFT, providers may need to submit an EFT authorization form or register with the MCPs third-party EFT vendor. Providers should ensure their information (such as provider name, NPI, tax ID, and billing zip code) is up to date with the MCP, including in the provider portal and on the EFT form, to avoid payment issues or delays.

Questions to ask MCPs

- How will I receive my remittance advice?
- What remittance advice code guidance or crosswalks could be provided to support claims corrections and/or resubmissions?
- If I do not agree with the claim payment determination, what is the process to file a claims payment dispute?

Claims Disputes

MCPs must have a dispute resolution process for LTC providers to challenge decisions on denied or incorrectly reimbursed claims. Providers should refer to the MCP contract, provider agreement, and MCP Provider Manual for the correct procedure and timeline for disputes. For additional questions, providers can contact the MCP LTSS liaison.

Recommended Practice: Reconciling Payments

Since MCPs pay LTC providers at different frequencies (daily, weekly, biweekly, etc.), it is highly recommended that providers set up a system to track and reconcile payments. This helps ensure all payments are received as expected, reducing errors and financial losses. Remember, the MCP is responsible for paying the contracted rate. Here are some suggestions for LTC providers to consider:[3]

Payment Reconciliation Tips

- Keep detailed and accurate billing records.
- Regularly audit billing records and payments.
- Maintain clear communication with insurance companies.
- Provide ongoing training for billing staff on insurance and reimbursement policies.
- Use software and tools to simplify reconciliation process.
- Set up clear procedures for the reconciliation process.

Questions and Resources

For questions about the managed care billing process, LTC providers can contact their MCP LTSS liaison. Additional billing information can also be found in DHCS resources, including the Carve-In FAQs and Resource Guides, published on each facility's webpage:

- Skilled Nursing Facility CalAIM Carve-In webpage
- Intermediate Care Facility for the Developmentally Disabled CalAIM Carve-In webpage
- Subacute Care Facility CalAIM Carve-In webpage

[3] *Reference: Adonis. (2024). The importance of reconciliation in medical billing. RSS. https://www.adonis.io/resources/the-importance-of-reconciliation-in-medical-billing#best-practices-for-effective-billing-reconciliation*