STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

March 23, 1984

To: All County Welfare Directors

Letter No. 84-8

MEDI-CAL ID CARDS -- RETROACTIVE INDICATOR

The purpose of this memo is to remind counties that the lack of an "R" retroactive indicator on Medi-Cal ID cards should have no effect on provider acceptance of labels.

In the past when a Medi-Cal ID card was issued for a month of eligibility which was prior to the month of issuance, the labels were coded with the "R" indicator. There was considerable confusion about the meaning of the "R" on the labels, particularly when providers were billing retroactively for services. The "R" coding on the labels was the Department's method of identifying the instances of retroactive eligibility determinations.

As described in Medi-Cal Bulletin No. 106, November 1979 (attached), a Medi-Cal provider should not refuse to accept a Medi-Cal label, printed without the "R" indicator, from recipients who present their Medi-Cal label after the month in which services have been rendered. When presentation of the label is made after the month of service and within one year following the month of service, the provider of service has two months from the date of label receipt to bill the Medi-Cal program. In these situations, the provider must certify in writing, on the face of a claim form, the date on which the proof of Medi-Cal eligibility was received. The deletion of the "R" indicator will have no impact on claims payment to Medi-Cal providers.

It should also be noted that for retroactive Treatment Authorization Requests (TARs), providers must attach a certification of retroactive eligibility from the county or the Notice of Action specifying retroactive eligibility.

The Department is in the process of sending another Medi-Cal Bulletin to remind Medi-Cal providers of the Department's policy on the issuance of Medi-Cal ID cards without the "R" indicator.

If you or your staff have any questions regarding this memo, please contact Dahlia Curry of my staff (916) 322-2715.

Sincerely,

Original signed by

Caroline Cabias, Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

MEDI-CAL BULLETIN

AN INFORMATION SERVICE OF
MEDI-CAL INTERMEDIARY OPERATIONS

No. 106 (Professional) 124 (Institutional) P.O. BOX 7924 • SAN FRANCISCO, CA 94120 November, 1979

MEDI-CAL BILLING LIMITATIONS

This article reviews the application of the billing limitation to Medi-Cal claims and updates those circumstances recognized by the Program as good cause for extension of the limit.

BASIC TWO-MONTH BILLING LIMITATION

Section 14115 of the Welfare and Institutions Code sets a two-month limitation on the submission of claims by Medi-Cal providers. Providers should bear in mind that the billing limit is measured from the first day of the month following the **month of service** to the date of claim **receipt** by MIO.

Definition of Month of Service

For Medi-Cal purposes, the month of service is defined as the month in which:

1. Single or multiple services are performed or an appliance is delivered. (This definition applies to the majority of Medi-Cal claims);
2. A trial period for appliances, hearing aids, and assistive devices is terminated;
3. A treatment plan is completed, as defined below.

Definition of a Treatment Plan

For Medi-Cal purposes, a treatment plan is defined as:

1. An authorized series of outpatient treatments with a specific number to be administered over a specified period of time (i.e., allergy or psychotherapy). In this situation, the completion of treatment is considered the date on which the last service is provided under the course of treatment or the date on which the Treatment Authorization Request (TAR) expires, whichever occurs first.
2. Maternity Services for which the date of delivery is considered the completion of treatment date.
3. An authorized and continuous acute hospital stay. In this situation, the date of discharge from the hospital is considered the completion of treatment date.
   Note: This provision applies only to claims submitted by acute hospitals or claims submitted by the patient's attending physician for professional services provided during the hospital stay.

For services which qualify under the definition of a treatment plan, a provider has the option of billing the Medi-Cal Program either upon completion of the treatment plan or on a monthly basis.

If a provider bills upon completion of a treatment plan, the claim must be received by MIO within two months following the final month of service. Claims submitted under this option must include a statement from the provider indicating that the billing represents a complete treatment plan.

Providers electing to bill on a monthly basis must bill MIO within two months following each month of service.

If the beneficiary is no longer a patient of the provider for whatever reasons (left the State, changed rovider) and the treatment plan is terminated, the provider should bill the Medi-Cal Program within two ionths following the month of the final service.

Proof of Eligibility

viders billing a global charge for maternity services must attach proof of eligibility for the month of lelivery. If a global charge is submitted for antepartum care only, proof of eligibility must be attached for he final month in which the patient was seen. For all other services, and for maternity services which re billed on a monthly basis, proof of eligibility must be attached for each separate month of service.

No claim is payable by Medi-Cal if it is not accompanied by proof of the patient's Medi-Cal eligibility. For nost providers, acceptable proof of eligibility is: POE label, MEDI label, copy of either label or copy of Medi-Cal card. Certain providers are restricted to original MEDI labels. SNF/ICF providers are restricted o original POE labels when billing for services provided to long term care beneficiaries with a share of ost.

EXCEPTIONS TO THE NORMAL TWO-MONTH BILLING LIMITATION

Sections 14019.3 and 14019.4 of the Welfare and Institutions Code specify that, upon presentation f a Medi-Cal card or label (for the appropriate month of service) by the beneficiary, the provider must ill the Medi-Cal Program. Sometimes patients, for various reasons, fail to make this presentation at or ear the time of service, causing providers delays in submitting claims to Medi-Cal.

Section 14115 of the Welfare and Institutions Code allows the Director of the Department of Health ervices to grant exceptions to the normal two-month billing limitation when delays are for good cause. he only good cause conditions under which Medi-Cal claims will be accepted for processing are as ollows:

. PATIENT FAILS TO PRESENT MEDI-CAL CARD AT TIME OF SERVICE, BUT DOES SO WITHIN ONE EAR FOLLOWING MONTH OF SERVICE.

A Medi-Cal beneficiary is considered to be a private patient until a Medi-Cal card or label for the appro- r month of service is presented to the provider. When presentation is made after the month of service nd within one year following the month of service, the provider of service has two months from the date f label receipt to bill the Medi-Cal Program. In these situations, the provider must certify in writing, on ne face of the claim form, the date on which the proof of Medi-Cal eligibility was received. In those few stances when an institutional provider has no space available on the claim form, the explanation may be ade on an attachment to the claim.

Examples of conditions which result in delayed card or label presentation are:

a. cases of emergency care in which patients could not make presentation.
b. cases in which patients do not volunteer information regarding Medi-Cal eligibility to the provider until they receive billings from the provider.
c. cases in which patients have left their Medi-Cal cards at home.
d. cases in which Medi-Cal eligibility determinations are not made until after the provider has rendered services. In these situations, the Medi-Cal card will carry the word RETRO and the month of eligibility on each label will be preceded by a "R".

If presentation is made during the month of service, the normal two-month limitation applies and affected claims are due within two-months following the month of service.

2. PATIENT FAILS TO PRESENT LABEL AT THE TIME OF SERVICE, BUT DOES SO AFTER ONE YEAR FOLLOWING THE MONTH OF SERVICE.

When presentation is made more than one year following the month of service, Medi-Cal will accept a claim for processing only when the delay was caused by a governmental administrative error or urt decision which is attested to in writing. In addition to the appropriate proof of eligibility, a claim ust carry one of the following attachments:

a. a copy of a letter from the appropriate county welfare office or the Department of Health Services confirming that eligibility was delayed due to an administrative error.
b. a copy of a court order or fair hearing decision granting retroactive eligibility or coverage of medical benefits under the Medi-Cal Program.

Such claims must be received by MIO within two months from the date the provider receives appropriate labels and documentation.

In all other cases of presentation after one year, claims will not be accepted by Medi-Cal.

3. OTHER COVERAGE, INCLUDING MEDICARE

Other coverage is defined as services for which a Medi-Cal beneficiary is eligible under any private group or individual indemnification program, state medical care program or federal medical care program. The liability of third parties in accident or injury cases, including industrial injuries, is not included in the definition of other coverage.

All providers are required to bill Medicare, CHAMPUS, Ross-Loos or Kaiser* before billing Medi-Cal. For any other health insurance carriers, a provider has the option of billing the other coverage carrier before billing Medi-Cal. Providers electing to bill the other insurance carrier should not bill Medi-Cal until the other carrier has issued a payment or denial notice. Under no circumstances should providers bill Medi-Cal and other coverage simultaneously.

When an other coverage carrier is billed first, the limitations for Medi-Cal claims are as follows:

a. **Medicare**
As most Medicare claims for professional services automatically cross over to Medi-Cal, the provider does not have to bill Medi-Cal separately. However, when the Medicare claim does not automatically cross over (as with institutional claims) the provider must bill the balance to Medi-Cal within two months following receipt of the Medicare remittance advice (R/A) or explanation of benefits (EOB), as long as the R/A or EOB was received within one year following the month of service. Any crossover claim received beyond one year following the month of service will not be processed by Medi-Cal unless the delay was caused by Medicare. In this situation, the delay must be substantiated when the claim is submitted to MIO.

b. **Non-Medicare**
The provider must bill Medi-Cal within two months following receipt of the other coverage carrier's remittance advice (R/A), notice of denial or non-liability, or check voucher, as long as the R/A or voucher is received within one year following the month of service. If the claim is beyond one year following the month of service, no residual payments will be made by Medi-Cal unless the delay was caused by the other coverage carrier. The delay must be substantiated when the claim is submitted to Medi-Cal.

In each instance, the Medi-Cal claim must be accompanied by a copy of the carrier's remittance advice, check voucher or notice of denial or non-liability.

4. AUTHORIZATION DELAYS AND APPEALS

When Treatment Authorization (TAR) is delayed by the Medi-Cal Field Office for a period greater than one month following the month of service, the provider must bill Medi-Cal within two months following:

a. the date of signature on the TAR by the Medi-Cal Field Office Consultant and within one year following the month of service, when non-emergency services were rendered pursuant to receipt of verbal authorization, or on a weekend or holiday and the provider made written request for treatment authorization within a reasonable time (10 days or less) following delivery of the service. A statement as to these circumstances must accompany the claim.

*Refer to Medi-Cal Bulletin No. 96 (Professional) No. 113 (Institutional) January 1973 for a listing of services not covered by Kaiser.

b. the date of signature on the TAR by the Medi-Cal Field Office Consultant when the authorization was the result of the provider's formal grievance in accordance with Title 22, Section 51003. A copy of the letter granting the appeal must accompany the claim.

5 RESUBMISSION OF RETURNED CLAIMS

Claims that are returned to the provider for additional documentation are to be resubmitted to MIO within two months following the month of return, unless the return was made for proof of eligibility (POE). POE returns are subject to the limitations outlined in 1 and 2, above.

GENERAL BILLING REQUIREMENTS

In addition to meeting the criteria outlined in this article, claims submitted beyond the two-month billing limitation must comply with all other established Program requirements, i.e., original MEDI labels when necessary, POE labels or photocopies of ID cards, TARs, operative reports, prescriptions and discharge summaries, when appropriate. Providers with questions concerning the billing limitation should contact their local MIO offices.

Providers must bill California Children Services (CCS) and the Genetically Handicapped Person's Program (GHPP) within the same time limitations as specified for any other Medi-Cal claim. CCS and GHPP are not considered to be other coverage carriers.

RETROACTIVE MEDI-CAL CARDS (CODED R)

In the past, some providers have refused to accept a label from a timely issued card when presentation occurred after the month of service. Instead, those providers asked the affected Medi-Cal beneficiaries to consult their eligibility workers and obtain retroactive Medi-Cal cards, which would be coded with a "R" preceding the month of eligibility. This practice should not continue. The "R" coding does not have any impact on claims payment. For your information, the "R" coding is the Department's method of identifying instances of retroactive eligibility determinations. The county welfare departments have been instructed to indicate retroactivity only in cases where the beneficiary's eligibility is not determined until after the month of eligibility.

MEDI-CAL BULLETIN

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