Section K: Claims and Billing Guidelines

K1: Claims Billing

CenCal Health follows the Medi-Cal guidelines and benefits outlined in the Manuals published by the State of California, with a few exceptions. Please see Benefits and Exclusions information for specific programs found in the Benefits Summary section of this Provider Manual. For specific claim questions, you may contact our Claims Customer Service Representatives. The address and telephone number for the Claims Customer Service Team is listed at the end of this section.

Below is a listing of bullet points outlining the general billing requirements. Bullets apply to all programs, except where specific programs are indicated:

- Claims may be submitted electronically (HIPAA compliant format), through a clearinghouse, via our Website at www.cencalhealth.org, or on a hard copy claim form.
- "Clean" claims will be processed within 45 working days of receipt. Clean claims are claims that include all of the necessary and accurate and valid data for adjudication. This includes, but is not limited to, name, gender, date of birth, subscriber number of member; ICD-10 diagnosis code(s), CPT/HCPCS codes, modifiers, billed charges, applicable authorization number(s), place of service, quantity of services, bill type and the NPI – National Provider Identification number.
- For Contracted Providers, claims payment is payable at the contracted rate. Payment will not exceed billed charges unless specifically stated in the contract.
- For Non-Contracted Providers, claims payment is payable at the Medi-Cal rate; additionally, payment will not exceed billed charges.

Member administrative fees or surcharges: Under no circumstances whatsoever may a Provider collect or attempt to collect fees from a CenCal Health Member (Medi-Cal beneficiary) for any non-clinical or administrative services, including but not limited to fees for: enrollment or subscription, appointment access, filling out forms or prescriptions, or for late arrival or absence from an appointment (also known as "no-show" fees). Providers must refer any CenCal Health Member who is habitually late to or absent from appointments to CenCal Health's Member Services department. CenCal Health will follow-up with the Member and provide any education or outreach needed. Providers must immediately return any such collected fees to the Member, and may be subject to termination from the network for violating this policy. Any such fees not returned to the Member may be withheld from future claim payments to the Provider.

Ambulatory Surgery Centers and Surgical Implant Billing: For Ambulatory Surgery Center (ASC) facilities in the CenCal Health network that are paid according to Medicare rates, it is acknowledged that Medicare typically

bundles in the value of surgical implants to the global facility fee paid to ASC facilities. The ASC fee is thusly inclusive of the cost of those surgical implants.

CenCal Health has identified a list of surgical Implant Procedures (below) involving the use of implanted devices and associated supplies, whose value is included in the Medicare ASC fee schedule rate paid by CenCal Health, including but not limited to:

Implant Procedure	Associated CPT Procedure Codes
Joint Replacement Surgery	27446, 27447
Pacemakers	33206, 33207, 33208, 33212, 33213, 33214, 33221, 33227, 33228, 33229
Defibrillators	33230, 33231, 33240, 33249, 33262, 33263, 33264, 33270, 33271
Cardiac Event Recorders	33282
Infusion Pumps	62360, 62361, 62362
Neurostimulators	61885, 61886, 63650, 63663, 63664, 63685, 64568, 64575, 64580, 64581, and 64590
Cochlear Implants	69930

Implants and supplies billed by ASC facilities in conjunction with the above Implant Procedures are not eligible for separate reimbursement if the facility is reimbursed at Medicare rates. The Associated CPT Procedure Codes are provided as a reference – any changes to CPT codes associated with the Implant Procedures described above may be incorporated to this policy at any time, at the sole discretion of CenCal Health.

Whole Child Model (WCM) and California Children's Services (CCS)

Effective July 01, 2018, CenCal Health assumed the responsibility of both Santa Barbara and San Luis Obispo counties for the Utilization and Claims payment for CCS eligible members that reside in these counties. Providers must be CCS certified for the specialty services they render.

Standard CenCal Health claim submission, claim correction, dispute/appeal, and timely filing requirements as outlined elsewhere in the Provider Manual and on our website also apply to claims for CCS services rendered to CenCal Health members.

Baby/NICU services may need to be billed using the mother's Member ID for the first two months of life beginning with the month of birth and ensure the correct relationship code is utilized.

Please visit the CenCal Health website for additional Claims and Billing Guidelines or the Medi-Cal Manual.

Denied Claims

Providers are requested to review denial explain code(s), correct the issue(s), and rebill the claim for further consideration of payment. CenCal Health must receive any corrections within 6 months from the date of the Explanation of Payment on which the claim originally appeared. Any corrections received after the end of the sixth month will not be considered.

Claims received after 6 months from initial Explanation of Payment date or month in which services were rendered are subject to payment reduction.

Prohibited Claims

CenCal Health, its Providers, subcontractors, and downstream subcontractors are required to comply with 22 CCR sections 53866, 53220, and 53222 with regard to the submission and recovery of claims for Medi-Cal covered services.

CenCal Health, its Providers, subcontractors, and downstream subcontractors shall not submit a claim to, demand, or otherwise collect reimbursement from, a Member or persons acting on behalf of a Member for any Medi-Cal Covered Services except to collect third-party payment in accordance with 22 CCR section 53222(a), or payment for non-covered services provided pursuant to 22 CCR section 53210(d). Even in the event of CenCal Health's failure to pay for Covered Services, Providers, subcontractors, and downstream subcontractors are prohibited from billing or attempting to collect from Members (other than copayments) and shall hold harmless the Members and the State.

Recovery from third party sources for Medi-Cal Covered Services rendered to a Member may be allowed, to the extent that such Member is covered for such services under any other state or federal medical care program or under other contractual or legal entitlement, including but not limited to, a private group or individual indemnification program. However, recovery shall not be attempted in circumstances involving casualty insurance, tort liability or worker's compensation. Circumstances which may result in casualty insurance payments, tort liability payments, or workers' compensation awards shall be reported to DHCS within ten days after discovery.

Disputes

If you do not agree with any decision made by CenCal Health with respect to payment or denial, you may dispute the decision. Submit a Dispute Form with all the information, including any attachments/documentation, for consideration of payment within 6 months of the initial EOP date. The appropriate staff member will review your dispute and you will be informed of the decision, in writing, within 45 working days of receipt of the dispute. This applies to all CenCal Health programs.

Appeals

An appeal may be submitted to contest the processing, payment or non-payment of a previously submitted dispute. Providers must submit in writing within 90 days of the action/inaction precipitating the complaint. Failure to submit an appeal within this 90-day period will result in the appeal being denied.

CONTACT INFORMATION FOR CLAIMS:

Submit Original Claims to:

CenCal Health
P.O. Box 948
Goleta, CA 93116-0948

Send Claim Disputes and Appeals:

CenCal Health
Attention: Claims Department
4050 Calle Real
Santa Barbara, CA 93110

Telephone Claim Inquiries:

805-685-9525 ext. 1083
800-421-2560 ext. 1083

Email Inquiries:

CencalClaims@Cencalhealth.org

K2: Payment Procedures for CenCal Health Members

Billing and Payment for Inpatient Services

A day of service is billed and reimbursed for each Member who occupies an inpatient bed at 12:00 midnight in the Hospital facility. Regarding a newborn, the mother's ID number may be used for the baby for the month of birth and through the end of the second month following birth. Once a newborn is assigned his/her own Medi-Cal identification number, that number will be used on all future claims and the mother's ID can no longer be submitted.

Hospital should not separately bill for outpatient, urgent care, and emergency services provided to a Member within twenty-four (24) hours of the admission of the Member to Hospital when the foregoing services are directly related to the condition(s) for which the Member is admitted to Hospital.

Claims Submission Timeliness

Providers shall bill CenCal Health for medical services on the UB-04 or its successor, on the CMS-1500 or its successor, or in an electronic format using industry standards as specified by CenCal Health and/or Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed by the parties. In order to qualify for full payment, Hospitals should submit the claims form to CenCal Health within one hundred and eighty (180) days from the date of service for professional/outpatient claims. Claims received in the 7th to 9th month from the date of service will be paid at 75% of the allowable, and claims received in the 10th to 12th month from the date of service will be paid at the 50% of the allowable.

Claims that are submitted after one year from the date of service will not be considered without a valid reason for the delay and supportive documentation.

Providers shall comply with existing State and Federal law and regulations pertaining to the issuance of explanations of payment (EOP's) for CenCal Health Members. Additional information on EOP's can be found in the Claims Section of this Provider Manual.

Providers shall be aware that any other health program (including Medicare) must be billed and recoveries made prior to billing State programs. Such rules shall also apply to CenCal Health's administration of the Medi-Cal Program. If CenCal Health receives a claim and determines that another insurance has been, or should have been billed, CenCal Health shall process such claims, reduce payment, or deny claims as appropriate, with notice of such reduction or denial indicated on the EOP. See proceeding section on Other Health Coverage Section K3 of the Provider Manual.

Claims Processing

CenCal Health will receive and process a clean claim in a timely manner and according to standards set forth in the Hospital Services Agreement, the EDS manual or in this Provider Manual.

Payment Requirements/Responsibilities with the Prudent Layperson Standard for Emergency Services

The determination of whether the prudent layperson standard was met, as defined in the definition of Emergency Services, Article 1, Definitions, of the Agreement, and in the AUTHORIZATIONS section of the Provider Obligations section of this Provider Manual will be made on a case-by-case basis. Except that CenCal Health coverage may be based on diagnosis code and may set reasonable claim payment deadlines.

CenCal Health may not deny coverage solely based on diagnosis code(s), nor deny coverage of this basis and then require submission of the claim as part of an appeal process. Prior to denying coverage or modifying a claim for payment, CenCal Health will determine whether the prudent layperson standard has been met on the basis of all pertinent documentation, with focus on the presenting symptoms (and not on the final

diagnosis). Additionally, CenCal Health will take into account that the decision to seek Emergency Services was made by a prudent layperson (rather than a medical professional).

Emergency Room, Urgent Care, and Treatment/Exam Room Claims Processing

Hospital should follow the general guidelines as indicated in the Claims Section of this Provider Manual when billing these claim types.

Inquiries and Appeals Regarding Claims Processing and/or Payment

If the Hospital has an inquiry or an appeal concerning the processing or payment of its claims by CenCal Health for services provided, CenCal Health has established procedures to accommodate the Hospital's desire to have its inquiry or appeal heard, evaluated, and resolved.

K3: Other Health Coverage (OHC) and SBHI & SLOHI

Other Health Coverage (OHC) refers to private health insurance. Services may include medical, dental, vision, pharmacy, and/or Medicare supplemental plans (Part C & D).A person covered under CenCal Health may also have other private/group health insurance. Having private/group health insurance does not affect a member's Medi-Cal eligibility in any way.

However, if you are not a participating provider of a recipient's Other Health Coverage (OHC), you should advise the member to obtain services through his other insurance or Health Maintenance Organization (HMO) Primary Care Physician (PCP) or refer them to a provider who participates in that plan. For instance, if you are the member's PCP through CenCal Health but not the member's PCP through Blue Cross HMO, you should refer the member to their Blue Cross HMO or obtain a treatment authorization from the HMO. CenCal Health will not reimburse for services not authorized by the HMO. If you are not an authorized provider of the recipient's HMO, please refer the member to their HMO and/or ask the member to contact the CenCal Health Member Services Department to reselect a PCP who participates in both programs.

Federal and state laws require Medi-Cal beneficiaries to report OHC to ensure Medi-Cal is the payer of last resort. Which means in most cases Medi-Cal will be secondary to the OHC, covering allowable costs not paid by the primary insurance up to the Medi-Cal rate. When Medi-Cal learns that a beneficiary has OHC, the Medi-Cal record is than updated to reflect the OHC.

K4: Billing for Members Who Have Other Coverage

State law mandates Medi-Cal to be payer of last resort, and requires the utilization of other available healthcare coverage prior to the utilization of Medi-Cal. Other coverage is always the primary payer and cannot be waived by the member. We ask that you always bill the member's other coverage first prior to billing CenCal Health. If the other coverage denies payment, a copy of the Explanation of Payment (EOP) or denial letter must be sent with your claim to CenCal Health. A list of services that can be billed directly to CenCal Health can be found in the Medi-Cal manual section under Other Health Coverage (OHC): CPT and HCPCS Codes

Providers are required to notify CenCal Health if they believe a member may be entitled to health coverage through a private/group health insurance plan or policy that is not indicated on the member's eligibility record. Providers should call CenCal Health's Finance Department, Recoveries Unit at (805) 562-1081 to report possible other insurance coverage. Providers are prohibited from billing members' other insurance copayment amounts for Eligible Members with Other Coverage.

Locating Recipient's OHC Information:
The Medi-Cal eligibility verification system returns a message that includes OHC information, when known. The eligibility verification system is accessed through the Automated Eligibility Verification System (AEVS) Medi-Cal website at www.medical.ca.gov

If the member has other health coverage, claims must be received within 60 days from the date of the EOP from the other health carrier to be considered for full payment. Claims received after 60 days from the EOP date fall back to Medi-Cal Submission and Timelines guidelines.

CenCal Health will reimburse the provider up to the Medi-Cal allowable, less the other health coverage payment amount but will not exceed the member's coinsurance amount. CenCal Health will not pay the balance of a provider's bill when the provider has an agreement with the other health coverage to accept its contracted rate as "payment in full".

If the recipient elects to seek services not covered by CenCal Health, CenCal Health is not liable for the cost of those services.

K5: What You Should Know About Medicare HMOs

The Other Health Coverage code "F" identifies Medi-Cal members who receive benefits from Medicare-contracted Health Maintenance Organizations (HMO) in lieu of the fee-for-service Medicare plan. Members who have both Medi-Cal coverage and Medicare HMO coverage must seek medical treatment through the Medicare HMO first. CenCal Health will not pay for the services if the patient elects to go to a provider who is non-participating with the primary plan for care. However, CenCal Health will reimburse for services which are Medi-Cal covered benefits, but which are not covered by the Medicare HMO plan.

Medi-Cal claims for members with Medicare HMO coverage may not be Medicare/Medi-Cal crossover claims (see below). Therefore, to bill Medi-Cal for services not included in the Medicare HMO plan, submit a Medi-Cal claim accompanied by a Remittance Advice (RA), Medicare Remittance Detail, or denial letter showing that the Medicare HMO was billed first.

K6: Medicare/Medi-Cal Crossover Claims

Claims for members who are eligible for both Medicare and Medi-Cal coverage must be billed to Medicare (either electronically or on paper) prior to billing Medi-Cal, with the exception of Medicare non-covered services. A list of Medicare Non-Covered Services can be found in the Medi-Cal manual section under "medi non cpt" and "medi non hcp." CenCal Health may reimburse providers for the Medicare deductible and coinsurance. A claim for Medicare deductible and coinsurance amounts is called a crossover claim.

Medicare uses a consolidated Coordination of Benefits Contractor (COBC) to automatically cross over to Medi-Cal for claims billed to any Medicare contractor for Medicare/Medi-Cal eligible recipients. Note: Providers do not need to rebill to Medi-Cal for claims that automatically cross over.

The California Welfare and Institutions Code (WIC) limits Medi-Cal payments of the deductible and coinsurance to an amount which, when combined with the Medicare payment, should not exceed the amount paid by Medi-Cal for similar services. The combined Medicare/Medi-Cal payment for all services of a claim may not exceed the amounts allowed by CenCal Health.
Providers who accept a patient who is eligible for both Medicare and Medi-Cal cannot bill the member for the Medicare deductible and coinsurance amounts; these amounts can be billed to CenCal Health. However, the provider should bill the patient for his/her share of cost, if any. Providers are encouraged to wait until they receive the Medicare payment prior to collecting the share of cost to avoid collecting amounts greater than the Medicare deductible and/or coinsurance.

Please note: CenCal Health lifted the Referral Authorization Form (RAF) requirement for crossover services. RAFs are still required for non-Medicare benefits for which Medi-Cal will be the primary payer.

Claims submitted to Medicare electronically will automatically crossover to CenCal Health for processing. These claims should appear on your EOP within 45 working days. If your claim has not appeared on an EOP

within this timeframe, you can submit your claims via the portal or electronically through your EDI clearing-house. For further assistance please contact your Claims Service Representative at 805-562-1083.
If you have any questions about what other coverage a member has, what carrier to bill first, Other Health Coverage codes or third-party coverage questions, please contact the Recoveries Unit at (805) 562-1081.

Reference Link:
Medicare Non-Covered Services: CPT Codes
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/6B724B76-FE3C-4C5D-9F16-44301101CD64/medinoncpt.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

Medicare Non-Covered Services: HCPCS Codes
https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/E18FD10B-3F5D-4610-902E-9106A3DF2591/medinonhcp.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO

K7: Recoveries of Overpayments to Providers

Per APL 23-011 - Each MCP must require, and have a mechanism for, Network Providers to report to the MCP when they have received an overpayment, to return the overpayment to the MCP within 60 calendar days after the date on which the overpayment was identified, and to notify the MCP in writing of the reason for the overpayment.

Providers may report any overpayments in one of the following ways:

- Email: Recoveries Department recoveries@cencalhealth.org
- Fax: (805) 681-3077
- Mail: CenCal Health, Attn: Recoveries Department, 4050 Calle Real, Santa Barbara CA 93110

Providers must include the following claim information on any overpayment communication to ensure accurate identification and application of funds:

- CCN – Claim Number
- Date of Service
- Member ID#
- Refund reason
    - Any associated backup documents

Reference Link:
Department of Health Care Services APL 23-011
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-011.pdf