SECTION XII – CLAIMING INFORMATION

BACKGROUND

Network providers are reimbursed by the Local Mental Health Plan (LMHP) under the rules and guidelines established for Phase II Medi-Cal Consolidation which was effective June 1, 1998.

The LMHP amended its claiming system and the way in which Los Angeles County Medi-Cal beneficiary data is received and processed to comply with Federal mandates. The federal government enacted the Health Insurance Portability and Accountability Act (HIPAA) to improve efficiency in healthcare delivery by standardizing electronic patient health, administrative and financial data and by developing security standards to protect the confidentiality and integrity of patient health information. Entities covered by HIPAA include mental health plans, clearinghouses, and billing agents/services, which are required to transmit mental health care data in a way that is compliant with, and regulated by, HIPAA.

In January 2014, the LMHP implemented the Integrated Behavioral Health Information System (IBHIS), an electronic health record system for the Los Angeles County Department of Mental Health (DMH). IBHIS integrates a broad range of functionality including referral management, client registration, appointment scheduling, clinical documentation, workflow support, authorization, billing, claiming and reporting, along with providing the base for the electronic exchange of clinical information with other healthcare providers. This is an integrated, web-based electronic system that is accessible and available around-the-clock that receives and processes protected health information (PHI) and claims data in a format that complies with HIPAA. The LMHP does not accept manual hardcopy claims from network providers.

When the LMHP receives HIPAA-compliant electronic claims from network providers, billing agents/services and clearinghouses, they are forwarded to the California Department of Health Care Services (DHCS) for adjudication as Short-Doyle/Medi-Cal (SD/MC) service claims. Payments made to network providers are based on IBHIS approvals. The LMHP will recover from network providers denied claim amounts resulting from the DHCS adjudication of SD/MC services. The LMHP shall be held harmless from and against any loss to network providers resulting from any such State denials, unresolved explanation of benefit claims, and/or Federal and/or State audit disallowances.

New network providers are required to enroll or register in the IBHIS. A Dun & Bradstreet (DUNS) number is required to confirm the provider identity in the enrollment process. The providers will be able to create, save, update and submit a Trading Partner Agreement (TPA) request online.

CLAIMING AND ACCURACY OF CLAIMS DATA

Network providers submit HIPAA-compliant claims for reimbursement of their services in the IBHIS via Electronic Data Interchange (EDI)/Secure File Transfer (SFT) or they can hire a billing agent/service or clearinghouse to submit the claims on behalf of them.

Network providers are requested to thoroughly review the accuracy of claims data before providing information to billing agents/services or clearinghouses to process. Invalid claims data

may prevent and prolong timely reimbursements or the ability to successfully pass EDI/SFT testing requirements. Due to the nature of most billing agents'/services' and clearinghouses' businesses, they simply format data files received from their network providers and are not responsible for data content. Therefore, network providers are required to ensure that all claims submitted to the LMHP on their behalf are as follows:

1) HIPAA-compliant;
2) Reimbursable by the LMHP, i.e.:
   - Procedure codes are HIPAA-compliant and appropriately submitted in the IBHIS as reflected in *A Guide to Procedure Codes for Claiming Mental Health Services* (Refer to Section IX: Procedure Codes, Diagnosis Codes and Rates). Procedure codes are valid for the network provider's taxonomy and contain the appropriate units of measurement (minutes) and service time; and,
   - Diagnosis codes are HIPAA-compliant and appropriately submitted (Refer to Section IX: Procedure Codes, Diagnosis Codes and Rates);
3) Submitted with valid DMH Client IDs. Network providers and their billing agents/services or clearinghouses use ProviderConnect application to search for clients and obtain the DMH Client ID. ProviderConnect application is a web-based interface used to communicate with IBHIS;
4) Submitted subsequent to being registered in the IBHIS;
5) Entered using the correct IBHIS FFS Provider ID: The number will be issued to the provider, billing agent/service or clearinghouse when their EDI/SFT applications are approved for testing;
6) Submitted with a valid National Provider Identifier (NPI) number and according to the requirements listed in the EDI/SFT IBHIS 837 5010 Companion Guide.
7) Submitted with a valid authorization number. There are 2 types of authorizations. They are Member Authorization and Funding Source Authorization. Network providers will put only 1 authorization on a claim line. Member Authorization is specific to a client and used for specific services (e.g. inpatient professional services) and duration of time. Member Authorization numbers are all numeric. Funding Source Authorization is for specialty mental health services given by DMH annually according to the disciplines of the providers. Funding Source Authorizations begin with an 'F', followed by a number.
8) Contain valid HIPAA Delay Reason Codes if necessary;
9) Compliant with the EDI/SFT IBHIS 837 5010 Companion Guide, which is available at: http://file.lacounty.gov/SDSinter/dmh/1064092_LACDMH8375010CompanionGuide.pdf

Claims submitted in the IBHIS without the information listed above during testing and in production will be denied**.**

VALID CHARACTERS

The following valid characters may assist users in avoiding claim denials, negative eligibility and enrollment responses due to invalid character transmissions:

Approved Alphabet Format
"A" through "Z"
"a" through "z"

Approved Numbers
"0" through "9"

Approved Symbols
Dash " - "
Number sign: "#"
Period: "."
Ampersand: "&"

Beneficiary eligibility, enrollment and claims data received by DMH containing characters other than those identified and approved above will cause a denial and may delay successful EDI testing results.

SUPPLEMENTAL NETWORK PROVIDER CLAIMING INFORMATION

The information listed below provides additional claiming requirements essential for network provider compliance:

- Network providers are required to supply the LMHP with their valid National Provider Identifier (NPI) numbers as follows:
    1. Individual providers are required to furnish their type I NPI number;
    2. Individual providers incorporated are required to furnish their incorporation's type II NPI and their rendering providers' type I NPI numbers; and
    3. Group providers are required to furnish their group's type II NPI number and their rendering providers' type I NPI numbers
- Contact the National Plan and Providers Enumeration System at the following website address to apply for an NPI number: https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions
- Network providers submit claims using the American Medical Association's Physicians' Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes. Network providers are reimbursed after IBHIS adjudication at the LMHP rates (Refer to Section IX: Procedure Codes, Diagnosis Codes and Rates).
- Network providers must list the starting time and ending time of the session in the client's chart and the number of minutes on the electronic claim to ensure full validation of time spent in the delivery of services to Medi-Cal beneficiaries. This rule is necessary to substantiate claims when the definition of the service involves time. In previous years, LMHP's data analysis using minimum times for service confirmed that some network providers were billing for over 20 hours daily. These claims are unacceptable and subject to recoupment. The LMHP will only reimburse for any appropriate and documented sessions.
- Proof of Medi-Cal beneficiary eligibility – Network providers must obtain and keep proof of Medi-Cal beneficiaries' eligibility for each month they receive services.
- The completed Uniform Method of Determining Ability to Pay (UMDAP) is required for all Medi-Cal beneficiaries. The UMDAP instructions are included in Section XI:

Financial Screening. Each network provider must keep UMDAP and other financial information either in a separate financial folder or in the medical chart.

- All accounting records and supporting documents must be retained by network providers for ten years after the closing of the fiscal year or until such time as the audit has been settled for the fiscal year. A licensed psychologist shall retain a patient's health service records for a minimum of seven years from the patient's discharge date. If the patient is a minor, the patient's health service records shall be retained for a minimum of seven years from the date the patient reaches 18 years of age.
- All network providers must be credentialed and entered on the LMHP's Network Provider Master File by the Provider Credentialing Unit.
- Network providers are only paid for services rendered while under a contract with the LMHP, approved by the Board of Supervisors and contingent upon active license and credentials.

  Note: The LMHP does not have authority to retroactively pay for services provided outside of the credential/license/contract effective and expiration dates.

- Claims must be electronically submitted to the LMHP to be processed, approved, converted to a SD/MC claim format and then transmitted to the DHCS.
- Network providers are responsible to ensure claims are submitted in a timely manner and denied claims are promptly corrected and resubmitted in order to comply with all applicable statutes of limitations, or risk loss of reimbursement for their services. Claims that do not reach the LMHP in time to be processed, approved and transmitted to the DHCS within six months from the date of service will be considered late. Under special circumstances, a valid HIPAA Delay Reason Code provided by the State must be entered on claims over the six-month billing limitation but under the one year billing limit to be accepted for claim adjudication.
- The LMHP is not obligated to reimburse network providers for the services covered by any claim if provider submits the claim to County more than one hundred eighty (180) calendar days after the date provider renders the services, or more than ninety (90) calendar days after the contract terminates, whichever is earlier. Additionally, the LMHP is not obligated to reimburse Contractor where the claim does not meet applicable Short Doyle SD/MC requirements.
- Roughly 30% of all claims are denied. In most cases these denials are correctable if reviewed and resubmitted promptly. Network providers, billing agents/services and clearinghouses are to actively monitor the claims response files to reconcile and determine the status of claims that have been received and adjudicated in the IBHIS.

DENIAL REASON EDIT CODES

The "IBHIS Denial and Adjustment Codes" is a list of denial reasons by type and code found on 835 file used to assist network providers, billing agents/services and clearinghouses with the reconciliation of denied claims. The list can be downloaded at the following website address:

http://file.lacounty.gov/SDSInter/dmh/1049812_IBHISMSODenialandAdjustmentCodes_20181207_.pdf

Users are to monitor the claim response files daily and correct claims eligible for rectification in a timely manner.

REIMBURSEMENT TIMELINE

Network providers are reimbursed based on IBHIS approvals to comply with the DHCS certified public expenditure requirements. The LMHP will recover from network provider's amounts denied by the State. Network providers shall hold County harmless from and against any loss resulting from any such State denials, unresolved explanation of benefit claims, and/or Federal and/or State audit disallowances. The reimbursement timeline is four to seven weeks from the date of claim submission.

CERTIFICATION OF MEDI-CAL CLAIMS

The California Code of Regulations, Title 9, Section 1840.112 requires that LMHPs provide certification of compliance with specific statutory, regulatory and contractual obligations that are required for Medi-Cal reimbursement of Short-Doyle/Medi-Cal claims. The Director of Mental Health certifies each monthly claim prior to submission to the State for reimbursement.

The LMHP is unable to certify claims submitted by network providers and Short-Doyle/Medi-Cal Providers and, therefore, requires that each network provider certify that Medi-Cal claims meet Federal and State regulations and statutes annually by completing the Certification on Medi-Cal Claim form in the FFS Medi-Cal Professional Services Agreement packet.

ON-LINE VENDOR REGISTRATION REQUIREMENT

In order to receive payments, network providers are required to register as a vendor with the County of Los Angeles, Internal Services Department (ISD) at the following website address: http://camisvr.co.la.ca.us/webven/. It is recommended that network providers confirm in the system, via the "Vendor Search" link, whether a registration has already been completed before starting the registration process. Registrants should also be prepared to enter the network provider's tax ID.

Click on the "New Registration" link at the website listed above and select the scenario that best fits the network provider's current status.

Note: The network provider's name and address must be exactly the same as the billing address used on their credentialing application and contract to avoid reimbursement delays. In the event that a change of billing address becomes necessary, network providers must also update their ISD vendor registration by selecting "Change Registration" at the website listed above in a timely manner to avoid reimbursement delays.

Please contact ISD Vendor Relations at (323) 267-2725 or email at: ISDVendorRelations@isd.lacounty.gov for questions regarding vendor registration.

ATTESTATION REGARDING FEDERALLY FUNDED PROGRAMS

The LMHP network provider legal agreement requires that each provider certify that he/she is not currently excluded from participation in any federally funded health care program or that a recent or current investigation would likely result in exclusion from any federally funded health care program.

Network providers must certify on the *Attestation Regarding Federally Funded Programs* form in the FFS Medi-Cal Professional Services Agreement packet that they will notify the LMHP within thirty (30) days in writing of:

- Any event that would require exclusion or suspension under federally funded health care programs, or

- Any suspension or exclusionary action taken by an agency of the federal or state government against the provider barring the provider from providing goods or services for which federally funded healthcare program payment may be made.

RESOURCE INFORMATION DOCUMENTS AND ONLINE SERVICES

FEE FOR SERVICE (FFS2) BULLETINS

Network providers, billing agents/services and clearinghouses should regularly review the FFS2 Bulletins for the latest updates regarding issues that may affect billing requirements. The FFS2 Bulletins may be accessed at the following website address: https://dmh.lacounty.gov/pc/cp/ffs2/

INTERNET REPORTS

Network providers and authorized users may access various reports on the DMH Internet Reports Application to review claim adjudication status and payment records.

The following reports are available:

1. FFS2 Claims Status Detail Report (CIOB 704)
    - A list of claims submitted with claims' statuses and adjudication detail.
2. FFS2 Processed Claims Summary Report (CIOB 705A)
    - A list of checks with sequence numbers received by the Provider.
3. Claims Reconciliation Report (CIOB 706A)
    - A list of provisional approved/paid claims and State denied claims. Sequence number is required, which can be found in CIOB 705A Report.

Use Google Chrome or Microsoft Edge Chromium Windows Operating System to run Internet Reports. To access the Los Angeles County Mental Health SSLVPN DMH Contactor Login page, navigate to DMH Contractor page:
https://era.lacounty.gov/dmh/contractor/mfa.

The Internet Reports Quick Reference Guide for DMH Contractors is available at the DMH Reports web page:
https://dmh.lacounty.gov/rc/c/reports/

If you have any questions or need additional assistance, you may submit a HEAT ticket to DMH using the HEAT Self Service application available on the LACDMH secure website: DMH SSLVPN, or contact the DMH Help Desk at (213) 351-1335 or helpdesk@dmh.lacounty.gov to get your SSLVPN password reset. You may contact the ISD Help Desk for contractor account password reset at (562) 940-3305.