RMD Bulletin

Knowledge is power…

SDMC2 Gross Billing Enhancement: Reporting of Detailed Adjustments

Later this week, the Los Angeles County Department of Mental Health (DMH) will be implementing a new function in the Integrated System (IS) that will bring provider billing further into compliance with the State Department of Mental Health's (State DMH or the State) Short-Doyle/Medi-Cal Phase II (SDMC2) gross billing requirements. Effective **Thursday, October 13, 2011**, providers will be required to include on all crossover claims to Medi-Cal the actual HIPAA compliant adjustment codes they received from other payers that were billed prior to Medi-Cal.

Background

Since we began instructing on changes to the IS for SDMC2, providers have been informed that when a client has coverage in addition to Medi-Cal (e.g., Medicare or private insurance), the State requires providers to demonstrate that they have billed the other payer and received an approval or denial. Providers were told that they must demonstrate this by including specific adjudication information on the Medi-Cal portion of the claim: the subscriber identification, the amount paid by the other payer, and the adjudication date. We also stated that later, providers would also need to send the specific adjustment reason codes to explain why the claim was not paid in full by the other payer. This week's change to the IS allows providers to include this information.

Procedure

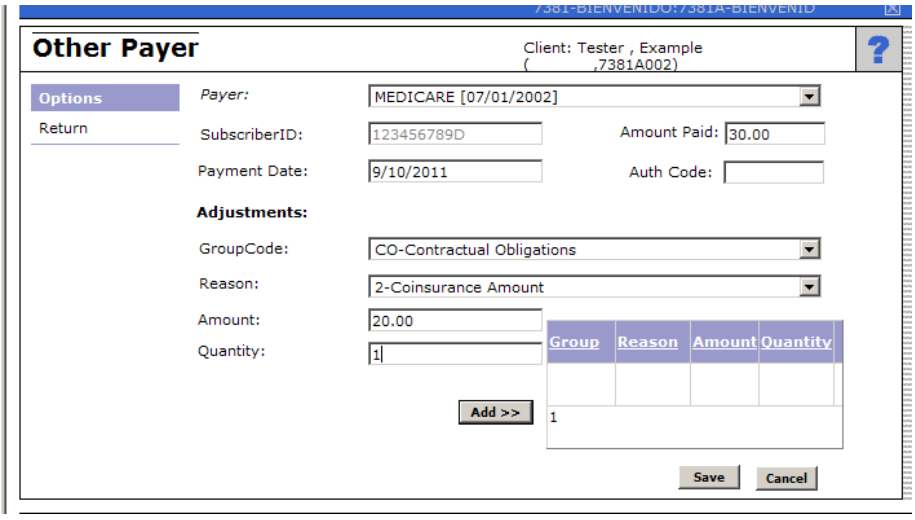
The general business rule for the gross billing requirement remains the same. Except as expressly allowed by State DMH, the rule is that Medi-Cal should be billed last when a client's services are covered by other payers in addition to Medi-Cal. To submit a crossover claim in the IS (Medi/Medi or Private Insurance/Medi-Cal),

Step 1. After receiving an approval or denial from the private insurance, assure that the amount claimed to Medi-Cal is the same as the amount claimed to the other payer. If the amounts are not the same, change the claim amount in the IS to match the amount claimed to the other payer. If the amounts do not match, the claim may not balance and the IS will not process your claim.

Step 2. Enter the subscriber identification, the amount paid by the other payer, and the adjudication date as previously instructed when the Other Payer screen was first introduced.

Step 3. For every claim that was adjudicated by a prior payer, find the adjustment groups and reason codes and the dollar amounts associated with each on the Remittance Notice or Explanation of Benefits (EOB) to enter into the IS on the Other Payer Screen.

- Review the Remittance Notice or EOB received from the other payer. Look for the adjustment groups and reason codes and the dollar amounts associated with each for every claim on the remittance.
- Select the Group Code from the drop down list.
- Select the Reason number associated with the group code from the drop down list.
- Enter the dollar amount represented by that adjustment group/reason code combination in the Amount field.
- Enter the number of times that adjustment and amount were returned by the payer for that adjudicated claim.
- Click the Add button.
- **Repeat for each Adjustment Group/Reason Code combination on the adjudicated claim.**
- Save when done entering all of the detailed adjudication information from the prior payer.



Special Situations

➙ Please note that other payers do not return HIPAA compliant adjustments on claims that were submitted on paper. Providers will not find those codes on the drop down lists on the Other Payer screen. Revenue Management Division is developing a crosswalk to assist providers in selecting the most appropriate

HIPAA compliant code to use on claims to the State. The crosswalk will be distributed in a separate RMD Bulletin.

- In the event that you have submitted a claim to the client's other health coverage and you have not received an approval or denial from that other payer within ninety (90) days, then the claim can be submitted to Medi-Cal. On the Other Payer screen, enter $0.00 as the Amount Paid and use the Adjustment Group **OA** and the adjustment reason code **A7** for the entire claim amount. (Note that use of this adjustment code means that after submitting the claim to the other payer, you have contacted the payer on a regular basis to follow up on the status of your claim and that these payer contacts have been documented in the client's financial folder.)

Remember, the Amount Paid plus all of the adjustment amounts must equal the Claim Amount. If they do not, the claim will not balance and the IS will not send the claim to Medi-Cal.

We're here to help you…

If you have any questions or require further information, please contact RMD at (213) 480-3444 or RevenueManagement@dmh.lacounty.gov.