CBO Bulletin

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REPLACEMENT CLAIMS IN IBHIS UNDER CalAIM

Replacement claims allow providers to submit updates or corrections to previously approved or denied claims and keep the date the original claim was received. Contract providers may replace most Medi-Cal or non-Medi-Cal claims; however, claims may be replaced only under certain conditions.

What follows is updated guidance on replacing claims in the Integrated Behavioral Health Information System (IBHIS). The information below updates the instruction provided in CBO Bulletin NGA 20-007: Updated Guidance on Replacement Claims in IBHIS to incorporate changes that began under California Advancing and Improving Medi-Cal (CalAIM) and supersedes the guidance provided in CBO Dispatch NGA 17-003: Replacement Claims in IBHIS.

Claims eligible to be replaced

- Claims that have been accepted by the system and have a Payer Claim Control Number/unique claim ID on the Department of Mental Health (DMH) 835.
- Medi-Cal claims originally submitted and received by the State within 12 months of the month of service, as long as the replacement claim is received by the State within 15 months of the month of service. *See restrictions below.*
- Non-Medi-Cal claims

Examples of when to send replacement claims

- Adding adjudication from a primary third-party payer
- Adding a KTA indicator
- After adding pregnancy information to the client's record
- Correcting lockout denials
- Changing Provider Authorization (P-Auth)/Funding Plan

  Warning: *Changing P-Auths can impact plan dollars.*

  - *When replacing claims to change the P-Auth/Funding Plan, only replace claims originally submitted with a Medi-Cal P-Auth with another Medi-Cal P-Auth and only replace claims originally submitted with a non-Medi-Cal P-Auth with a claim using another non-Medi-Cal P-Auth.*
  - *Changing P-Auths impacts Funding Plan dollars. Ensure that there is enough funding in the new P-Auth to cover the replacement claim.*

Claims that cannot be replaced

- Claims that were not accepted by IBHIS (no 277CA for claims).
- Claims that have not received an 835 yet.
- Claims denied by the State for late submission.

- Claims that need the Medi-Cal Client Index Number (CIN) corrected/changed.
    - The State sees claims with a different CIN as a claim for a different client. The State does not allow a claim for one client to replace a claim for a different client. Correcting or changing a CIN requires a new original claim (with the correct CIN) to be submitted. The steps to correct/change the CIN depends upon the reason for the change.
        - The CIN was never correct for the client: Update the client's Financial Eligibility to correct the CIN and submit a new original claim. (Ask your vendor how to do this within your Electronic Health Record (EHR).) IBHIS will use the corrected CIN on the outbound claim to the state.
            - Void any approved claims with the incorrect CIN.
        - The client's CIN changed for a date of service: Please refer to CBO Dispatch #NGA 16-031 – Handling CIN Changes in IBHIS. Remember, you must submit a new original claim when a new CIN has been added to the client's record.

Restrictions

- Only claims that have a Claim Frequency Code of 7 (i.e., CLM05-3 = 7) in the 837 are considered replacements.
- Claims can be replaced more than once, but the replacement claim submitted must refer to the last valid claim. (Ask your vendor about how to accomplish this in your system.)
- Medi-Cal replacement claims cannot include changes to more than two (2) of the following four (4) elements.
    - The procedure or revenue code.
    - The date of service.
    - The place of service.
    - The Service Facility NPI.

  Changes to more than two of these elements will cause the replacement claim to be denied by the State.
- Medi-Cal will reject claims with procedure codes that were deleted after July 1, 2023. Use HEAT to contact DMH for substitute procedure codes recommended by the American Medical Association (AMA).
- Medi-Cal has strict deadlines for original and replacement claims. Follow the claims submission timeliness terms in the Legal Entity contract to allow adequate processing time for claims to meet Medi-Cal's timeliness rules.
- Medi-Cal claims cannot be replaced with non-Medi-Cal claims. This is true for approved and denied Medi-Cal claims. To change Medi-Cal claims to non-Medi-Cal, providers must void the Medi-Cal claim and submit a new, original, non-Medi-Cal claim.
- Non-Medi-Cal claims cannot be replaced with Medi-Cal claims. This is true for approved and denied non-Medi-Cal claims. To change non-Medi-Cal claims to Medi-Cal, providers must void the non-Medi-Cal claim and submit a new, original, Medi-Cal claim.
- Replacements of non-Medi-Cal claims must be received by DMH within eight (8) months from the month of service.