Section 10
Claims

The Alliance follows the billing, authorization, utilization management and claims payment guidelines laid out by the Medi-Cal Provider Manual or the Explanation of Coverage (EOC) and related regulations for the other lines of business, as appropriate to the patient. However, there are a number of instances in which the Alliance has decided to differ from these standard procedures and practices. Please see below for areas where the Alliance's policies and procedures differ from those of the state Medi-Cal program or to clarify how a provider is to operate pursuant to a policy and procedure for all lines of business.

Billing Guidelines

Medi-Cal Managed Care Encounter Data Reporting

Background

In accordance with federal regulations, Department of Health Care Services (DHCS) contractually requires that Medi-Cal Managed Care Plans (MCPs) submit to DHCS complete, accurate, and timely encounter data for services provided to enrolled beneficiaries. Prior to November 2014, MCPs traditionally met their contractual requirement to submit encounter data to DHCS utilizing a variety of proprietary and standard formats. After November 1, 2014, DHCS implemented a new system to receive and process encounter data in the national standard transactions, ASC X12 837 5010 and NCPDP. This new system was implemented to meet state and federal Medicaid monitoring and reporting requirements and to accommodate receipt of ICD10 Diagnosis Codes in accordance with HIPAA requirements.

Effective January 1, 2015, DHCS, in support of its ongoing encounter data quality improvement initiatives, only accepts national standard file formats and coding schemes for managed care encounter data submissions. By May 2015, all MCPs had transitioned from the previous proprietary formats to production encounter data submissions in the national standard formats.

In order to comply with DHCS requirements, claims may be denied and require re-billing based on the guidelines set forth by DHCS.

Medi-Cal

Since the Alliance serves Medi-Cal beneficiaries under a contract with the state to operate a County Organized Health System (COHS) the Alliance uses state policies and procedures as a point of departure. Unless there is an Alliance-specific policy, we rely on state Medi-Cal policies for the Medi-Cal program. Providers have access to all of the policies and procedures, as well as updates to the Medi-Cal Provider Manuals on the Alliance provider website.

Alliance Care IHSS

Please apply your commercial insurance office policies, including procedure codes and UB 04 and CMS form completion.

Clean Claim

A clean claim is defined as a claim which, when it is originally submitted, contains all necessary information, attachments, and supplemental information or documentation needed to determine payer liability, and make timely payment. Total charges on a clean claim match all services billed on that page/form.

Where to Send Claims

Paper claims should be mailed to the Alliance using the following addresses to facilitate timely processing and payment.

Medi-Cal (including Medi-Cal members with CCS eligibility)
ATTN: CLAIMS
Central California Alliance for Health
PO Box 660015
Scotts Valley, CA 95067-0015

Alliance Care IHSS
ATTN: CLAIMS
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066

Claims inquiries that require documentation may be faxed to the Claims Department at (831) 430-5868.

Claim Questions

Alliance providers are encouraged to use their Provider Portal for claims inquiries. If there are any additional questions, call the Claims Department at (831) 430-5503 or (800) 700-3874 ext.5503, Monday – Friday, 9:00 AM – 4:00 PM.

Office hours for the Claims Department phones are Monday – Friday, 9:00 AM – 4:00 PM, with a 24-hour voicemail available for messages. Any provider calling from outside of the local calling area may use the Alliance's toll-free number. The Alliance toll-free number may be dialed from anywhere in the United States (all 50 states) as well as Canada.

Alliance phone numbers are:

Main office: (831) 430-5500
Toll-free number: (800) 700-3874
TTY Line: (877) 548-0857
Claims Department Phone Staff: (831) 430-5503
Fax number: (831) 430-5868
Provider Relations: (800) 700-3874 x5504

When calling about questions on a claim, please have the following information available:

- The Alliance Claims Control Number (CCN) and/or the Member's Alliance ID number (if the inquiry is regarding a newborn claim billed under the mother's ID number, please indicate this at the beginning of the call).
- Date of service.
- Dollar amount billed.
- Date claim was sent to Alliance.

Billing for State Medi-Cal Program

Effective 10/01/2019 DXC Technology serves as the Medi-Cal Fiscal Intermediary for the state Medi-Cal program. If you treat a member who is not an Alliance Medi-Cal member, you must bill DXC or the member's Medi-Cal plan for those services. This rule applies to members whose eligibility is through another county or who have an aid-code not covered by the Alliance.

For questions and inquiries, please contact DXC directly at (800) 541-5555.

Electronic Claims Processing

The Alliance accepts and encourages claims submitted electronically. Electronic claims processing or Electronic Data Interchange (EDI) refers to the structured transmission of data between organizations by electronic means. Please see the "Information about Electronic Transactions" content later in this section for a detailed description of the EDI submission process.

Turnaround Time for Claim Reimbursement

If you believe that the Alliance has not processed your file within 30 days of our expected received date, please contact the Alliance Claims Department at (800) 700-3874 ext.5503. If you have received an RA where the claims were processed electronically and you have questions regarding the payment / denial outcome, please contact the Alliance Claims department at (800) 700-3874 ext.5503.

Claim Forms by Provider Type

The following table is a list of the types of paper claim forms used by different types of providers (e.g., PCPs, referral specialists, pharmacists, laboratories, hospitals, skilled nursing facilities and allied health practitioners).

Claim Forms Used by Different Types of Providers

Applies to	Type of Claim Form	Type of Provider	Service(s) Billed on This Form
Medi-Cal, Alliance Care IHSS	CMS	PCPs Specialists Clinics Pharmacies Laboratories Allied health practitioners	All professional services Electronic Medicare/Medi-Cal crossover professional claims effective on April 9, 2018. Pharmacies may also use this form for DME, medical supplies, incontinence supplies, orthotics and prosthetics.
Medi-Cal	PM-160	PCPs	Child Health & Disability Program (CHDP) services for dates of service before 12/31/17 *only* — and *only* used for Medi-Cal members. For dates of service on or after 1/1/18, these services must be billed on a standard CMS or UB claim form.
Medi-Cal, Alliance Care IHSS	UB-04	Hospitals/Clinics Laboratories	All professional or facility services. SNF levels of care services when billed by approved facilities for Medi-Cal members.
Medi-Cal, Alliance Care IHSS	25-1C	LTC	All LTC services billed with accommodation codes.
Medi-Cal, Alliance Care IHSS	30-1	Pharmacies	Non-compound drug prescriptions.
Medi-Cal, Alliance Care IHSS	30-4	Pharmacies	Compound drug prescriptions

Adherence to the following checklist for effective submission of claims will assure timely payment:

- ✓ Print/type clearly on Claim Forms: All claims submitted must be legible and dark enough for scanning, which will prevent your claims from being returned.
- ✓ Bill on 8-1/2 x 11 paper (including attachments).
- ✓ Be sure to include the patient's full name, without abbreviating.
- ✓ Always include the member's Alliance ID Number :(Box #1a on the CMS, Box #60 on the UB): Please bill all claims using the Alliance Member 9-digit ID number (the "-01" at the end of the Alliance ID number is not required). Please *do not use the 14-digit Medi-Cal identification number*.
- ✓ Include Authorization Numbers (Box #63 on the UB or Box 23 on the CMS): Type all AR and referral numbers on the claim.
- ✓ When services were provided in the ER, indicate this by marking box 24C on the CMS if you are not billing with a place of service in an ER setting.
- ✓ Note that a quantity for each service rendered is required: please enter quantities as a single digit (e.g., "1" not "01," "001" or "010").
- ✓ For newborn services using mom's ID see the following claim form completion instructions in the Medi-Cal Provider Manuals:
    - CMS Completion (cms comp)
    - UB-04 Completion: Outpatient Services (ub comp op)
- ✓ For newborn services, if the infant is using the mother's eligibility (within the infant's month of birth and the month following birth), enter NEWBORN INFANT USING MOTHER'S ID or NEWBORN INFANT USING MOTHER'S ID (TWIN A) or (TWIN B) in the Reserved for Local Use field (box 19) on the **CMS**-On the **UB-04 claim form**, enter the infant's name in the Patient's Name field (Box 8B). Enter the infant's date of birth and sex in boxes 10 and 11. Enter the mother's name in the Insured's Name field (Box 58) and enter "03" (CHILD) in the Patient's Relationship to Insured filed (Box 59).
- ✓ Please *do not staple* attachments, as scanning equipment requires that all staples must be removed; thus, if we must perform this task, your claim may be delayed.
- ✓ Please do not fold claims, as this may delay processing. Claims control staff guarantees that all claims and attachments will be kept together exactly in the order you put them in the envelope.

Billing and Coding Information

The Alliance follows the billing, authorization, utilization management, and claims payment guidelines laid out by the Medi-Cal Provider Manual or the EOCs and related regulations for the other lines of business, as appropriate to the patient. However, there are a number of instances in which the Alliance has decided to differ from these standard procedures and practices. Please see below for areas where the Alliance's policies and procedures differ from those of the state Medi-Cal program or to clarify how a provider is to operate pursuant to a policy and procedure for all lines of business.

For information on specific procedures pursuant to a policy for all lines of business, please see below for Alliance billing guidelines:

Emergency Services (ER)

No prior authorization is required for emergency services

*P*roviders should contact the Alliance for verification of the member's eligibility.

Medi-Cal/CPT guidelines should be followed for correct coding and identification of claim/s billed as ER services.

Who bills Medi-Cal for the services of rendering providers and locum tenens physicians?

Rendering providers cannot bill directly; the group entity bills Medi-Cal for services rendered by the providers enrolled in their group. In reimbursement for locum tenens/reciprocal billing, the recipient's regular physician may submit the claim and receive payment for covered Medi-Cal services (including emergency visits and related services) provided by a locum tenens physician who is not an employee of the regular physician. Providers should bill with modifier Q6.

Allergen Immunotherapy, 95115

To enable contracted Ear Nose and Throat and allergist providers to accurately report and be reimbursed for services provided to all Alliance members, the Alliance will reimburse professional services for allergen immunotherapy (excluding provision of single allergenic extracts) billed with code 95115 when billed in conjunction with E&M codes 99201-99215 or 99241-99245.

No authorization or referral is required.

Ambulatory Surgery Billing and Authorizations

Surgical Implants: Prior authorization is required for surgical implants. The provider must submit an Authorization Request requesting Plan approval, and must attach supporting documentation regarding the implants to be used, their cost and the procedure in which they are to be used. If the implant is to be used in a procedure which itself requires prior authorization, a single Authorization Request should be used both requesting authorization for the procedure and for the implants. If the procedure itself would not otherwise require prior authorization, an Authorization Request for the implants only should be submitted.

Billing for Outpatient Surgical Facility Services: Unless otherwise specifically identified in this guide, covered outpatient surgical facility services and supplies which are not on a surgical tray, or a post-operative pain block, or a surgical implant should be billed using the appropriate Medi-Cal specific or CPT billing codes. As noted above, providers must follow any applicable prior authorization requirements applicable to the procedure being performed.

a. Surgical Tray: the Alliance pays a case rate for surgical supplies provided on the surgical tray. Providers must bill with the appropriate CPT-4 codes (range 10000-64399 & 64531-69999) and must include either a UA or UB modifier on the claim form.

b. Post-Operative Nerve Pain Blocks: the Alliance pays a flat rate for the provision of post-operative nerve pain blocks. Providers may bill for the provision of post-operative pain blocks administered to patients where the post-operative pain block was provided on the same date of service as the surgical procedure. Providers must bill using CPT-4 codes (range 64400-64530) and should use appropriate modifiers.

Surgical Implants: Providers billing for surgical implants must include a copy of the invoice for the item and the authorization number with the claim. See Policy 600-1011 - Surgical Implantable Devices.

Biophysical and Modified Biophysical Profile

The Alliance will reimburse contracted providers for biophysical and modified biophysical profiles without referral or authorization.

CPT 76818 – fetal biophysical profile (BPP), a test to measure fetal well-being.

CPT 76819 – modified biophysical profile, combines a non-stress test and measurements of amniotic fluid (amniotic fluid index).

Services are reimbursed when providers use the appropriate billing codes for the following scenarios:

For same date of service (DOS) and same provider, replace billing code (59025 + 76805) with 76818 only.

For different DOS and any provider, with service billed within 7 days, replace (59025 + 76805) with (59025 + 76819).

For same DOS and any provider, replace (59025 + 76805) with (59025 + 76819).

There is a diagnosis restriction for high-risk pregnancy. The Alliance will reimburse contracted providers for biophysical and modified biophysical profiles without referral or authorization for high risk pregnancy.

Members with CCS Eligibility

The CCS diagnosis code should only be added to claims in which the CCS condition is being treated

Cardiac and Pulmonary Rehabilitation Services

The Alliance provides coverage of cardiac and pulmonary rehabilitation services for all Alliance members with prior authorization. When billing for these services, please use the following codes:

Cardiac Rehabilitation: 93798, 93797, G0422, G0423

Pulmonary Rehabilitation: G0424

For additional information please see Policies 404-1720_Private_Duty_Nursing_EPSDT_Benefit and 404-1729 - Pulmonary Rehabilitation Services.

Chiropractic X-Ray Services

The Alliance will reimburse the following amounts for contracted chiropractors when providing specific X-ray services to all Alliance members. When billing for these services, chiropractors should use only the codes shown below with an appropriate modifier: See Policy 600-1036 - Modifier Reference Grid for assistance

Billing code: 72040 - Radiologic examination of spine (including cervical spine). No modifier (both professional and technical component), or Modifier 26 (just professional component).

Billing code: 72052 - Complete X-ray, including oblique and flexion and/or extension studies. No modifier (both professional and technical component), or Modifier 26 (just professional component).

Billing code: 72070 - Radiologic examination, spine, thoracic. No modifier (both professional and technical component), or Modifier 26 (just professional component).

Billing code: 72100 - Radiologic examination, spine, lumbosacral. No modifier (both professional and technical component), or Modifier 26 (just professional component).

Billing code: 72114 - Complete, including bending views. No modifier (both professional and technical component), or Modifier 26 (just professional component).

A referral or an Authorization Request is not required.

DME Policies and Instruction

600-1006 – Breast Pumps and Coordination of Benefits

600-1007 - DME Rent to Purchase Pricing

600-1022 - Charpentier Billing Procedure

600-1024 - DME Pricing

600-1026 - Incontinence and Medical Supply Pricing

600-1029 - Orthotics and Prosthetics Pricing

600-1032 - Wheelchair and Scooter Repair Mileage and Medicare Denials

600-1033 - Wheelchair, Wheelchair Accessories and or Replacement Parts for Patient Owned Equipment Pricing

600-1034 - Slings (A4565) Reimbursement

600-1801 – Claims Submission Guidelines and Rental Timeframes for Nebulizers

600-1802 – Claims Submission Guidelines and Rental Timeframes for TENS Devices

600-1803 – Claims Submission Guidelines and Rental Timeframes for Wheelchairs

600-1804 - Claims Submission Guidelines for an Osteogenesis Stimulator

600-1805 - Claims Submission Guidelines for Speech Generating Devices

Ear, Nose and Throat Services

The Alliance will reimburse for outpatient ear nose and throat (ENT) procedures without the need for an Authorization Request (AR); as long as the services are performed by an In Service Area or Local Out of Service Area contracted ENT physician and the correct codes and billing processes are used.

An In Service Area Provider is any provider based in the Alliance's Service Area, regardless of contract status. A Local Out of Service Area Provider is a specialist physician, hospital or allied provider based in an area adjacent to the Service Area, with whom the Alliance has contracted based on an existing referral pattern and claims payment to the provider, and the need for access to the provider's specialty type.

Procedures

A referral from the member's PCP will be required unless the member is an Administrative Member.

Use the following CPT codes when billing for ENT services: 42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836, 42860, 69424, 69433, 69436, 69440, 69450, 69631.

CCS review referral required for the following CPT codes: 42820, 42821, 42825, 42826, 42830, 42831, 42835, 42836, 42860, 69424, 69433, 69440, 69450.

CCS referral exception to the following CPT codes only: 69436 and 69631.

ECG Services

The Alliance will reimburse for outpatient ECGs without the need for a referral, as long as the services are performed by in an In Service Area or Local Out of Service Area contracted cardiologist (provider specialty 06), radiologist (provider specialty 30), or pediatric cardiologist (specialty 35) and the correct codes and billing process are used.

Specified ECG services will be covered when place of service 21 and/or 22 are billed in conjunction with ECG readings. No referral is required.

Use the following CPT codes when billing for ECG services:

93000	93005	93010	93015
93016	93017	93018	93024
93025	93040	93041	93042
93224	93226	93227	93228
93229	93268	93270	93271
93303	93304	93306	93307
93308	93312	93315	93318
93320	93321	93325	93350
93880			

Emergency Room Casting or Treatment

Referral will not be required for Alliance members who are referred by the emergency room to an orthopedic surgeon within the Alliance in-service and local –out of service area, for casting or treatment of bone fracture, including sprains and strains when services are billed with Diagnosis Code Ranges: M84-M8468XS, S02-S0292XS, S12-S129XXS, S22-S229XXS, S32-S329XXS, S42-S4292XS, S52-S5292XS, S62-S6292XS, S72-S7292XS, S82-S8292XS, S92-S92919S, T148, S93- S93699S.

Fecal Occult Blood Testing

The Alliance will authorize payment for fecal occult blood testing that is part of routine screening examination to rule out colorectal cancer in members between age 50 and 75. Billing code: 82270

Hearing Aids

The Alliance covers hearing aids when supplied by a hearing aid dispenser, the prescription of an otolaryngologist or the attending physician when no otolaryngologist is available in the community. An audiological evaluation, including a hearing aid evaluation performed by, or under the supervision of, the above prescribing physician, or by a licensed audiologist, is required. Prior authorization is required for the purchase or rental trial period of hearing aids and for repairs that cost more than $25 per repair service. The following CPT/HCPCS codes related to hearing aids will not be capped annually:

V5014;V5264;V5265;V5030;V5040;V5050;V5060;V5070;V5080;V5298;V5120;V5130;V5140;V5150;V5170;V5180;V5190;V5210;V5220;V5230;V5267.

Invoices

Invoice Date for any service requiring an invoice for pricing

This date must be prior to the date of service. The date of the invoice cannot be more than one year prior to the date of service.

Mileage Cost Reimbursement for Travel to Repair Wheelchairs/Scooters

The Alliance will cover mileage costs incurred by a provider when he/she goes to and from an Alliance member's home to repair wheelchairs/scooters.

Procedure code X2999 is an Alliance-only benefit that allows reimbursement for mileage when a provider goes to and from a member's home to make wheelchair repairs.

- Reimbursement is $0.32 per mile.
- X2999 falls under the same guidelines for Authorization Requests as repairs — i.e., an AR is required only if maintenance or repair (and/or travel) exceeds $500 (cumulative cost of related items within a group).
- This applies to Alliance primary members and Medicare/Alliance members only.

DME Serial Numbers

Providers will be required to include DME serial number notation when filing a claim for the following items: Concentrators and Ventilators, Speech Generating Devices, Hospital Beds, Wheelchairs and accessories, Lift Devices and accessories.

Miscellaneous Policies and Instruction

600-1001 - Claims Processing

600-1009 - Corrected Claim Submissions

600-1010 - Miscellaneous Drugs and Medical Supplies

600-1011 - Surgical Implantable Devices Z7610

600-1013 - Postoperative Pain Management

600-1015 - National Correct Coding Initiative

600-1016 - Non-Covered Service Billed with a GY Modifier to Medicare

600-1017 - Provider Inquiry and Dispute Resolution

600-1018 - Modifier Placement

600-1019 - Modifier 99 (Multiple Modifiers Not Recognized)

600-1030 - Reimbursement for Medicare Medi-Cal Crossover Nephrology and Dialysis Services

600-1031 - Twins Delivery Reimbursement

600-1036 - Modifier Reference Grid

600-1037 - Global Surgery

600-1039 - Billing for Time Based Anesthesia Services

600-1040 - Unbundled CPT Codes 69210 and 92557

600-1041 - Medicare and Coordination of Benefits Reimbursement

600-1043 - CHDP Program Reimbursement for Snellen Test

600-1044 – H0049 and G0442 CHDP Program for Alcohol Misuse Screening

600-1046 - Contraceptive Products and Services

600-1047 - Place of Service 20 (Urgent Carehttp://www.ccah-alliance.org/providerspdfs/pm/20200401/600-1047-POS-20-Urgent-Care.pdf) Billing Location Expansion

600-1048 - Manual Pricing of a Service When There is No Medi-Cal Rate

600-1072 – AB 72

Contraceptives A4267, A4268, A4269U1, A4269U2, A4269U3, A4269U4

When billing for contraceptives using the above codes, please bill by adding the total quantity dispensed in box 24G (Days or Units) of the CMS form or box 46 (Serv Units) of the UB04 claim form. Please note this process differs from Medi-Cal guidelines that instruct providers to bill with a quantity of 1 and then to add the description, quantity dispensed and at cost expense of the item to Remarks.

MMRV Vaccination

For Alliance Care IHSS members, this vaccination combines the attenuated virus MMR (measles, mumps, rubella) vaccine with the addition of the chickenpox vaccine (varicella).

- Providers billing for services rendered to non-Medi-Cal members should bill the MMRV using vaccine CPT code 90710.
- Each claim must be submitted with an invoice.
- These claims will be reimbursed at invoice cost plus an additional 5%.

Occupational and Speech Therapy Codes

In addition to the codes listed in the Medi-Cal Manual, the following CPT codes are to be used for claims submission:

Occupational Therapy: Billing Codes and Reimbursement Rates (occu cd)

Speech Therapy: Billing Codes and Reimbursement Rates (speech cd)

Occupational Therapy Codes (if CPT criteria met)		Speech Therapy Codes (if CPT criteria met)	
X4100 Medi-Cal claims only	Evaluation – initial 30 minutes, plus report	92507 Medi-Cal and Commercial claims	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
X4102 Medi-Cal claims only	Evaluation – each additional 15 minutes, plus report	92508 Medi-Cal and Commercial claims	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals
X4110 Medi-Cal claims only	Occupational Therapy - Treatment - Initial 30 Minutes		*Facilitated Communication:* There are no specific codes for facilitated communication
X4112 Medi-Cal claims only	Occupational Therapy - Treatment - Each Additional 15 Minutes		*Altered Auditory Feedback Devices:* There are no specific codes for altered auditory feedback devices
97140 Medi-Cal and Commercial claims	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes		
97535 Medi-Cal and Commercial claims	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes		

Physical Therapy Codes

The following CPT codes are to be used for Medi-Cal and commercial lines of business claims submission.

Do not use the billing codes in the Medi-Cal Manual.

Please note:

- X codes will not be accepted for claims or authorization submissions.
- Failure to use the appropriate modifier when billing physical therapy codes may result in denial of the claim.

Physical Therapy Codes for Medi-Cal Lines of Business (if CPT criteria met)			
99243	An initial Physical Therapy Evaluation – requires a referral from the member's linked Primary Care Physician (PCP) or treating physician.	97124	Massage, including effleurange, petrissage and/or tapotement (stroking, compression, percussion)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes, therapeutic exercises to develop strength and endurance, range of motion and flexibility.	97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97014	Application of a modality to 1 or more areas: electrical stimulation therapy		
97112	Neuromuscular reeducation (97112) of movement, balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities	97530	Therapeutic activities direct (one on one) patient contact by provider, each 15 minutes.
97113	Aquatic therapy with therapeutic exercises	97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes
97116	Gait Training includes stair climbing		

Refractive State Services Used for Claims Payments

Determination of refractive state includes determination of visual acuity with corrective lenses. It is usually performed with an instrument called a phoropter. While looking at an eye chart through the phoropter, the ophthalmologist adjusts the lenses until the chart appears the clearest possible.

Medi-Cal
Non-refractive services billed by ophthalmologists are potentially payable by the Alliance when billed with a primary medical diagnosis.

- Non-refractive services billed by approved optometrists are potentially payable by the Alliance when billed with a primary medical diagnosis.
- A referral is required from the member's PCP if the Alliance is the primary payer and the referring provider is within the Alliance's in-service area or local out of service area.
- An authorized referral is needed from a member's PCP if the Alliance is the primary payer and the referred to provider is out of the service area

For information on how to become an approved optometrist, please reference Policy 300-4160-Optometrists Reimbursement for Medical Services.

Wheelchair Evaluations

The Alliance will reimburse for wheelchair evaluation to help identify the wheelchair that best fits the members need. The evaluation can be requested by member, medical professional or Alliance staff.

Referral is required for evaluation by local qualified Network PT or Physiatrist and may be reimbursed when billed using one of two Billing Codes:

- X2995: Simple wheelchair evaluation
- X2997: Complex wheelchair evaluation

Evaluation by contracted DME Evaluator may be requested by DME provider, Alliance staff or provider. Referral is not necessary.

Information about Electronic Transactions

To expedite claims processing, the Alliance offers an electronic claims submission service for its providers. This section is designed to provide you with broad understanding of Electronic Data Interchange (EDI) transactions, and serves as a guide to the electronic claims processing at the Alliance.

What is EDI?

EDI refers to the structured transmission of data between organizations by electronic means. Organizations that send or receive documents between each other are referred to as "trading partners" in EDI terminology. The trading partners agree on the specific information that is to be transmitted and how it should be used.

Benefits

There are many benefits to sending your claims electronically to the Alliance, including:

- Decreased data entry errors > Faster payment.
- Reduced paper claim costs > No paper claims to print.
- Lower print costs > No ribbon or toner expense.
- Reduced mailing costs > No envelopes or stamps to buy.
- Decreased office costs > No overhead to print, sort, stuff and mail claims.
- Increased staff efficiency > Quicker claims turnaround time.

Acceptable Transaction File Formats

The Alliance accepts ANSI X12 HIPAA mandated compliant transactions.

For more information on HIPAA, please see the Wedi-Snip website and the Accredited Standards Committee website.

Clearinghouses

The Alliance can receive EDI files directly using a Secure File Transfer Protocol (SFTP) or through any clearinghouse.

The Alliance is currently affiliated with the following clearinghouses:

Office Ally
Contact Office Ally customer service at (866) 575-4120 or email info@officeally.com.

Payer ID is CCA01 (Professional and Institutional)

Change Healthcare
Contact Change Healthcare enrollment group at (866) 924-4634 or email PayerContact@changehealthcare.com

Payer ID is SX169 (Professional); 12K82 (Institutional)

ClaimRemedi
Contact ClaimRemedi enrollment group at (800) 763-8484 x3 or email

enrollment@claimremedi.com Payer ID is 95311 (Professional and Institutional).

If providers choose to work with Office Ally, **they can submit claims at no charge**. Please email the Alliance EDI Support Team at edisupport@ccah-alliance.org for further details.

Support

The Alliance EDI Unit can be reached directly at edisupport@ccah-alliance.org or by calling (800) 700-3874 ext.5510.If you are interested in submitting electronic claims, please complete, **sign** and submit the EDI Claims Enrollment form

Change Healthcare and ECHO Health, Inc. for all Fee-For-Service (FFS) and capitation payments beginning early fall of 2020

The Alliance is collaborating with third party vendors, Change Healthcare (CHC) and ECHO Health, Inc., to assist with payment processes. Providers will begin receiving payments from ECHO for Fee-For-Service (FFS) and capitation payments in the early fall of 2020.

ECHO is a leading provider of electronic solutions for payments to healthcare providers. ECHO consolidates individual provider and vendor payments into a single ERISA and HIPAA compliant format, remits electronic payments and supplies an explanation of provider payment details to providers.

There are three types of payment options available through ECHO:

- Virtual Credit Card (VCC)
- Electronic Funds Transfer (EFT)
- Paper Checks

Providers already enrolled to receive EFT from the Alliance, or through ECHO's All Payer option, will continue to receive EFT as their default method of payment. Providers who do not "opt out" or sign up for EFT will receive the VCC option as the default payment method. Providers will be able to call ECHO after the transition date and request to opt-out of the Virtual Credit Card payment option, if EFT or paper checks are preferred.

Read the FAQ guide for details.

If you have additional questions regarding your payment options, please contact ECHO Health at 888-984-0804.

For assistance with any technical support issues, contact ECHO Health customer service at 888-834-3511.

Frequently Asked Questions about Claims

9. Does the Alliance follow the same timeliness guidelines as Medi-Cal?

   Yes. For our Medi-Cal lines of business, the Alliance follows Medi-Cal Timeliness and Delay Reason Codes guidelines. Please see the Medi-Cal Provider Manual for further information.

10. How do I interpret information on the Alliance Remittance Advice (RA)?

    Please refer to the Alliance Remittance Advice Guide available on our provider website.

11. Will the Alliance accept electronic claims?

    Yes. The Alliance accepts and encourages electronic claims submission. If your practice or facility is interested in having your Alliance claims processed electronically, please contact our EDI Support Unit by emailing a completed EDI Claims Enrollment form to edisupport@ccah-alliance.org.

12. How can I enroll to receive an Electronic Remittance Advice (ERA)?

We have partnered with ECHO, a partner of Change Healthcare. For more information, you may send an e-mail to EDI@echohealthinc.com or call (888) 983-5574.

13. When and how should I follow-up on claims possibly held for processing by the Alliance?

Please consider the date the claim was mailed in estimating if follow-up or a request to re-bill is appropriate. Claims are processed based on the date of their receipt at our office. For most practices, the appropriate timeframe for follow-up would be 45 calendar days after the claim was originally mailed. We suggest that providers use the electronic tracking of claims available through our Provider Portal Services or call the Claims Customer Service Representative line Monday - Friday, 9:00 AM - 4:00 PM at (800) 700-3874 ext. 5503.

14. Can previously denied claims be resubmitted via the web?

Contracted providers may use the Provider Portal to search for claims and resubmit previously denied claims. If your office is not set up to use our Provider Portal, please contact your Provider Relations Representative for instructions on how to set up an account. Some restrictions may apply.

15. What form should I use to bill Child Health and Disability Prevention (CHDP) Program claims?

CHDP services performed with a date of service on or after January 1, 2018 must be billed using the CMS or UB claim forms or equivalent electronic claim transactions. PM 160 forms for services rendered on January 1, 2018 or after will not be accepted.

CHDP claims for services prior to January 1, 2018 were billed on a PM-160 form.

The Alliance will return any incomplete PM-160 forms to the provider before processing; therefore, please follow the CHDP guidelines provided by the state of California. Please visit the DHCS website and select "Programs" then "CHDP Manual and Bulletins" for complete information on the CHDP Provider Manual and program.

Note: Services rendered to Alliance Care IHSS members should be billed on CMS/UB04 forms using standard commercial insurance billing guidelines, as these programs are not applicable to CHDP or Medi-Cal. Non-CHDP Providers should bill using the CMS or UB-04 forms.

16. How should claims for newborns be submitted?

Services rendered to an infant in the month of birth and the month following birth may be billed under the mother's Alliance ID number as a Mom/Baby claim following Mom/Baby claim guidelines. A referral for services is not required during this timeframe. After this timeframe, the infant must have their own Alliance ID number.

- To bill correctly on the CMS form, ensure that the mother's Alliance ID number is in field 1A, the infant's name is in field 2, the infant's birth date is in field 3, and the Child box is checked in field 6.

- To bill correctly on the UB 04 form, ensure that the infant's name is in Box 8B, the infant's date of birth and sex are in Boxes 10 and 11, the mother's name is in Box 58, "03" (CHILD) is in Box 59, and the mother's Alliance ID number is in Box 60.

17. How does the Alliance process claims for children eligible for California Children's Services (CCS)?

Claim for dates of service prior to 7/1/18:
Original claims billed with a CCS diagnosis and/or a CCS-eligible condition will be denied.

A denial will also appear on a subsequent remittance advice. The outcome of the Alliance's review of potential CCS claims centers on the diagnosis listed by the provider's office. Some offices have billed non-CCS claims, resulting in slow payments or inappropriate denials.

Claims for dates of service after 7/1/18:
The Alliance will process CCS claims, with a few exceptions that are billed to State Medi-Cal.

Claims submitted to Alliance should include the CCS diagnosis code on the claim when treating the member for the CCS condition. Prior authorization is required – see Health Services Policy 404-1305_Screening_and_Referral_of_Medically_Eligible_Children_to_California_Childrens_Services_CCS_Program.

Since the Alliance has not changed the Medi-Cal coding/billing requirements from those required by Medi-Cal, you may use the Medi-Cal Provider Manual as your Alliance billing guide.

18. How should I handle Share-of-Cost (SOC) collection and billing?

Share-of-Cost (SOC) collection and billing is an important function for every provider's office. The Point of Service (POS) device or Automated Eligibility Verification System (AEVS) at (800) 456-2387 will inform you of a member's outstanding SOC and allow you to clear the amount collected (or the amount that the member is obligated to pay). Members with outstanding SOC amounts are not eligible to receive services under their Alliance membership until the SOC is collected and cleared. Once the amount collected (or the amount obligated) is cleared, the Alliance member will be eligible to obtain services (or will be closer to being eligible to obtain services if there is a remaining SOC amount). It is important for all providers to collect and clear SOC each month to ensure a member's ability to obtain services from other providers later that month.

Once a SOC has been collected, the Alliance will compute the Medi-Cal allowance and subtract the amount already paid by the member. If the member's payment exceeds the Medi-Cal allowance, then the Alliance reimbursement will be $0 (in such a case, you would not need to bill the Alliance for the services because you will have been paid more than Medi-Cal allows). If the member's payment is less than the Medi-Cal allowance, then the net reimbursement will be the difference.

- CMS claim form: Enter the amount collected (or obligated) in box #10d of the CMS claim form. The amount collected (or obligated) should also be entered in box #29 and should be subtracted from the total balance due (box #30).
- UB-04 claim form: Enter code "23" and the amount of the patient's SOC in box 39. In box 55 enter the difference between "Total Charges" (box 47) and SOC collected.

19. How are refunds or reversals/take backs processed?

Alliance Identified Overpayment:

Research is completed by Alliance staff to identify overpayments on claims. Overpayments may have been made due to a duplicate claim payment, lack of coordination of benefits with the member's primary health care insurance policy or incorrect billing procedures. When an overpayment is identified, the Alliance will mail a notification of overpayment to the provider requesting a refund.

Provider Identified Overpayment:

If a provider's business office identifies an overpayment, they are required to report when they received an overpayment, to return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Alliance in writing of the reason for the overpayment. Providers may fill out the Provider Identified Overpayment form that can be found in the Finance section of the Form Library of the Alliance website.

The provider should issue a refund check payable to:

Recoveries Department
Central California Alliance for Health
1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981

Please include the refund check with the Financial Control Number (FCN), date of service of the claim overpayment, patient's member ID number, reason for the refund and the claim number so that the recovery can be recorded to the proper account.

Alternatively, some providers prefer that recoveries are made electronically. If an electronic refund or reversal of an overpayment is preferred, please notify Recoveries staff at (800) 700-3874, ext. 5622 or send an e-mail to recoveriesadmin@ccah-alliance.org.

20. What do I do if I disagree with how a claim was paid or denied?

Providers may disagree with how a claim was priced/paid or whether or not it was denied appropriately. These issues can often be handled directly by the Claims Department without the involvement of Provider Services or Health Services departments. Please contact an Alliance Claims Customer Service Representative Monday - Friday, 9:00 a.m. - 4:00 p.m. at (800) 700-3874 ext. 5503.

In situations where you disagree with the Claims Department decision after calling, please contact your Provider Relations Representative who will evaluate the issues. For further information, please refer to the Alliance Provider Manual, Section 17, Resolution of Disputes and Grievances.

21. When can I bill an Alliance member for an unpaid service?

You may not bill an Alliance member for any unreimbursed amount, including a deductible/co-insurance or copay amount, unless one of the following exceptions applies:

- The member has an unmet monthly Medi-Cal share-of-cost amount.

- The member does not disclose their Alliance/Medi-Cal coverage.
- The member consents to receive services that are not covered by the Alliance.
- The member chooses to see a physician/provider who does not accept Medi-Cal or is not a Medi-Cal provider.
- The member waives their Medi-Cal benefits.
- The member does not obtain or access primary insurance benefits correctly.

Note also that, unless you have provided benefits to the member according to the primary insurance authorization/benefit requirements, you may not charge the Alliance member for the service.

22. Claim forms completion guidelines

All forms must be 8 ½ x 11 inches. Undersized attachments need to be taped to an 8 ½ x 11-inch sheet of white paper. The Alliance retains electronic images by using a scanner. The scanner does not accept anything other than a full sheet of 8 ½ x 11 paper.

- Do not staple or fold claims, and please use mailing envelopes that do not require you to fold your claims. During claims processing, all staples must be removed, and folded claims must be unfolded and smoothed flat before entering the scanner. These time-consuming tasks slow the process.
- Do not highlight information. When the form and attachments are scanned, the highlighted area will show up only as a black mark, obscuring the highlighted information. The result will most often be a denied claim.
- Do not strike over errors or use correction fluid. Cover incorrect data using correction tape and re-enter the correct information. All claims must be legible and dark enough for scanning.
- All hardcopy claims must be signed or initialed by an authorized staff person in your office unless there is an electronic signature waiver.
- Please bill all claims using the Alliance member ID number. The recipient's Alliance ID number, name (do not abbreviate), gender and the date of birth entered on the claim must match the information on the Alliance recipient's card. The "-01" at the end of the Alliance ID number is not required. It is not necessary to submit a Point of Service (POS) device printout as a claim attachment. Please do not use the fourteen-digit Medi-Cal identification number.

A quantity for each service rendered is required. Please enter quantities as a single digit (e.g., "1" not "01," "001" or "010"). Also, please do not include negative quantities.

23.

Billing Requirements for Hospital Inpatient Services: Statement Dates

In order to comply with Department of Health Care Services (DHCS) requirements, inpatient claims must only bill for services dated within the statement date. Codes dated prior to or after the statement date are billing incorrectly.

Codes that need to fall on or within the statement dates include: occurrence, principle procedure and other procedure. If the date of any code billed does not fall between the statement period dates, the claim is incorrectly completed and will be denied. See correct hardcopy UB-04 claim form examples below.

- **UB-04 Hardcopy, Field 6: Statement Covers Period**
  Enter the beginning and ending service dates of the entire period covered in the claim in MMDDYY format. For services provided on a single day, enter the date of service as both the "from" and "through" date. Any other codes submitted on the claim need to fall on or within the statement covers period dates.

- Electronic submission: 837I Loop 2300, Segment DTP with qualifier 434.

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
	08/01/19	08/03/19	

- **UB-04 Hardcopy, Fields 12-13: Admission / Start of Care Date and Admission Hour**
  Enter the date of admission for inpatient services. Enter in MMDDYY format. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day; this should not be altered.

  Enter the admit hour as follows: Eliminate the minutes and convert the hour of admission/discharge to 24-hour (00 – 23) format (for example, 3 p.m. = 15)

- Electronic submission: 837I Loop 2300, Segment DTP with qualifier 435.

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR
		08/01/19	15			

- **UB-04 Hardcopy, Fields 31-34: Occurrence Codes and Dates**
  Enter the code and associated date noting a significant event relating to the claim that may affect payer processing.

- **UB-04 Hardcopy, Fields 35-36: Occurrence Span Codes and Dates**
  Enter the code and the related dates that identify an event relating to the payment of the claim.

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH
11	08/01/19									

- **UB-04 Hardcopy, Field 74: Principal Procedure Code and Date**
  The ICD-10-CM code for the principal procedure and date performed.
- **UB-04 Hardcopy, Fields 74a – 74e: Other Procedure Codes and Dates**
  Enter the ICD-10-CM procedure codes and dates for up to 5 additional procedures.