Fall 1995 Bulletin No. 8

COUNTY OF LOS ANGELES/DEPARTMENT OF HEALTH SERVICES (DHS)

PHYSICIAN REIMBURSEMENT PROGRAM

Information Bulletin

Claim Denials Due to Medi-Cal Eligibility

It has come to our attention that some providers and billing companies are not aware of the current procedure for Medi-Cal match of all CHIP claims and handling of CHIP claims denied because of a Medi-Cal match. Failure to take appropriate action after denial due to Medi-Cal match can result in non-payment from either program.

The following information is being provided to assist you in this process:

■ Claims Submitted to AIA

Claims are processed and matched against the State Medi-Cal tape. If there is a Medi-Cal match, the claim is denied on the remittance advice (RA). The Medi-Cal number is provided to assist you in billing the Medi-Cal program.

Critical Point: Since Medi-Cal claims must be submitted to the State no later than one year after the month in which service was rendered, it is imperative that billing of Medi-Cal is initiated immediately upon receipt of the denied CHIP claim.

■ Medi-Cal Point of Service and EOB

For providers who use the Medi-Cal Point of Service, please be aware that we cannot accept the Point of Service Receipt as official Medi-Cal denial.

We can only accept the Medi-Cal Explanation of Benefits (EOB) submitted as verification of denial of payment by Medi-Cal, submitted along with the CHIP and HCFA-1500 forms. As soon as you have a Medi-Cal EOB denial, send it to AIA without delay.

■ Medi-Cal Denial Re-submissions

Medi-Cal Explanation of Benefits (EOB) may take in excess of 8 weeks, therefore, you should submit County denied claims to Medi-Cal as soon as possible after receiving the County RA with the Medi-Cal number.

If a Medi-Cal claim is subsequently denied due to ineligibility, PSIP procedures require re-submission within 30 days. In order to re-submit to the PSIP program, you must follow the written appeal procedures outlined in the Physician Enrollment package.

CPT CODING UPDATES

The following CPT coding issues have recently been reviewed by the Physician Reimbursement Advisory Committee:

91105 - Gastric Intubation
90780 - IV Infusion

These codes are under careful audit for excessive and inappropriate use for procedures intended to be performed by the physician or under direct physician supervision. Audits have shown that these procedures are most commonly performed by nurses.

99291 - Critical Care E & M
99292 - Each additional 30 minutes

PRAC has noted that Critical Care Codes are being inappropriately used for routine inpatient follow-up visits in critical care areas. Therefore, the PSIP program pays all claims using 99291 and 99292 codes during the first 24 hours only. After 24 hours, subsequent visits coded 99291 or 99292 will automatically be recoded and paid at **99231**. Providers can appeal the recoding by providing a discharge summary and treatment record for the dat fo service.