

## Pilot 1 Legal Entity Provider Readiness Testing: Claiming

Provider Claiming Readiness Testing will consist of four required phases. The first phase is verification with the provider that the IBHIS setup is complete and the types of services that will be tested. The second phase is verification that client's financial eligibility has been submitted correctly through Client Web Services. The third phase is a verification of the claiming scenarios. The fourth phase is a verification of Void and Replacement claiming scenarios.

Note: for testing purposes, all 837 Rendering Provider records must have been active in the IS as of January 2013.

### *IBHIS Setup and Testing Verification:*

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Provider and testing analyst will confirm the following information:

- 1) Submitter ID/DUNS Number
- 2) 835 Defaults – information that will appear on the providers 835s
- 3) Services that the provider will be claiming for – in addition to MediCal and Indigent (Non-Medi-Cal) outpatient services, does the provider claim for Katie A, Day Treatment (Day Treatment – Full and/or Half Day; Day Rehab – Full and/or Half Day), CalWORKs, COS, Inpatient, Residential or PHF services? Confirming the services provided will define the scenarios required to establish provider claiming readiness.

### *Verification of Client's Financial Eligibility:*

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Provider will create Clients and the related Financial Eligibility using Web Services for all identified provider services. The Provider will submit a listing of the Clients to the IBHIS Integration Team for validation.

- 1) MediCal Client: Financial Eligibility set up in Guarantor Order as follows:
  - (1) Guarantor ID 10 with Plan ID 1
  - (2) Guarantor ID 16 with Plan ID 2
- 2) Katie A MediCal Client: Financial Eligibility set up in Guarantor Order as follows:
  - (1) Guarantor ID 18 with Plan ID 1
  - (2) Guarantor ID 16 with Plan ID 2
- 3) Indigent Client (Non-Medi-Cal): Financial Eligibility set up in Guarantor Order as follows:
  - (1) Guarantor ID 16 with Plan ID 2
- 4) Medi-Medi or OHC-MediCal client:

For Medi-Medi, Financial Eligibility set up in Guarantor Order as follows:

  - (1) Guarantor ID 12 with Plan 3
  - (2) Guarantor ID 10 with Plan ID 1
  - (3) Guarantor ID 16 with Plan ID 2

For OHC-MediCal client, Financial Eligibility set up in Guarantor Order as follows:

  - (1) Guarantor ID for OHC payer at the discretion of the provider. (See Guarantor Listing) with Plan 5 for Guarantor IDs 20-164
  - (2) Guarantor ID 10 with Plan ID 1
  - (3) Guarantor ID 16 with Plan ID 2
- 5) Day Treatment client: Financial Eligibility set up in Guarantor Order as follows:
  - (1) Guarantor ID 10 with Plan ID 1
  - (2) Guarantor ID 16 with Plan ID 2
- 6) CalWORKS client: Financial Eligibility set up in Guarantor Order as follows:
  - (1) Guarantor ID 17 with Plan ID 6
  - (2) Guarantor ID 10 with Plan ID 10
  - (3) Guarantor ID 16 with Plan ID 2
- 7) Residential client: Residential Episode created at the Residential Program of Service level with Guarantor Order as follows:
  - (1) Guarantor ID 10 with Plan ID 1
  - (2) Guarantor ID 16 with Plan ID 2
- 8) Inpatient client: Inpatient Episode created at the Inpatient Program of Service level with Guarantor Order as follows:
  - (1) Guarantor ID 10 with Plan ID 1
  - (2) Guarantor ID 16 with Plan ID 2
- 9) PHF client: PHF Episode created at the PHF Program of Service level with Guarantor Order as follows:
  - (1) Guarantor ID 10 with Plan ID 1
  - (2) Guarantor ID 16 with Plan ID 2

### Claiming Cycle 1 Verification:

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Following the positive validation of the client's Financial Eligibility, the Provider will submit claims in the following listed scenarios, and while submitting the files, please adhere to the naming convention of <ProviderInitial>\_<DUNSnumber>\_837P\_Scen\_<Scenario Number>\_<YYYYMMDD> .txt (e.g. SSG\_000000000\_837P\_Scen1\_20140201.txt)

- 1) MediCal Client - Financial Eligibility for MediCal (10) and LA County (16)
  - a) One outpatient service utilizing a service code of the provider's choice
- 2) Katie A Client - Financial Eligibility for Katie A (18) and LA County (16)
  - a) One outpatient service utilizing a Katie A service code  
Note: the Katie A service codes are only used on claims that have 'SFC TFC-Treatment Foster Care MC' (004901), 'SFC Wraparound MC' (005001) and 'MHSA FSP Wraparound MC' (002201) authorizations.
- 3) Indigent Client (Non-Medi-Cal) - Financial Eligibility for LA County (16)
  - a) One outpatient service utilizing a service code using P Authorization for Non-MediCal Funding Source
- 4) Medi-Medi or OHC-MediCal Client
  - a) One outpatient service utilizing a service code with partial payment from payer (CO)
- 5) Day Treatment Client - DMH will provide the Member Authorization # and allowable dates of service for claiming as follows:
  - a) One Day Treatment or Day Rehab service code using the assigned M Authorization
- 6) CalWORKs Client
  - a) One CalWORKs service utilizing the CalWORKs P Authorization
- 7) Residential Client
  - a) One residential service
- 8) Inpatient Client
  - a) One inpatient service - Inpatient Hospital and/or Admin Hospital Day (mode 5)
- 9) PHF Client
  - a) One PHF service
- 10) COS Claim using the default COS client
  - a) One COS service

Claiming Cycle 1 verification will be considered complete when the provider has submitted an Approved claim for each category above.

### *Claiming Cycle 2 Verification:*

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Once the 1<sup>st</sup> cycle of Provider Claim Readiness has been validated and communicated to the Provider, the provider will submit 3 claims to Void and Replace claims that were submitted in the 1<sup>st</sup> claim cycle. The Provider will submit claims as follows:

- 1) Replace a Claim from Claiming Cycle 1 using the duplicate modifier '59'  
Note: the Katie A service codes do not use the '59' modifier. Do not replace the Scenario 2 claim using the duplicate modifier '59'  
Note: the non-Medi-Cal Funding Sources do not use the '59' modifier. Do not replace the Scenario 3 claim using the duplicate modifier '59'
- 2) Replace a Claim from Claiming Cycle 1 using the duplicate modifier '76'  
Note: the non-Medi-Cal Funding Sources do not use the '76' modifier. Do not replace the Scenario 3 claim using the duplicate modifier '76'
- 3) Void an Approved Claim from Claiming Cycle 1  
Note: submit the Void scenario after you've completed the two Replacement scenarios.

Claiming Cycle 2 verification will be considered complete when the provider has submitted an Approved claim for each category above.