

Pilot 1 FFS Provider Readiness Testing: Claiming.

FFS Provider Claiming Readiness Testing will consist of 4 required phases.

- 1) Provider setup:** IBHIS Setup and Testing Verification.
- 2) Client setup:** Create admission, Create Financial Eligibility and Create Over Threshold Authorization.
- 3) Claim Adjudication:** Claiming Cycle 1 Verification.
- 4) Claim void and Replacement:** Claiming Cycle 2 Verification.

1. IBHIS Setup and Testing Verification(Responsible Individual(s) LAC DMH, FFS Provider):

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) Use the Funding Source Authorizations listed below.
- 4) Provider to confirm which two clients need to be used for testing. Provider to supply the two IS client IDs that needs to be used for testing.
- 5) Does the provider provide Med. support services?
If so med support scenario needs to be tested, otherwise it can be ignored.
- 6) Obtain the IS Client ID, Procedure Code to be used for over threshold claim testing from the provider. This is required to create member based authorization for OTAR.
- 7) Which client (IS Client ID) to have OHC Guarantor and Provider to supply which OHC guarantor to be used.

Here are the currently available Funding Source Authorizations. Submit claims for dates of service prior to the submit date using the appropriate Funding Source Authorization (Based on the begin date and end date).

Funding Source ID	Funding Source	Plan Name	Authorization #	Begin Date	End Date
1002	FFS2 Under Threshold non MD	FFS2 Outpt Under Threshold non MD (CGF)	F2	1/1/2014	4/30/2014
1003	FFS2 Under Threshold MD	FFS2 Outpt UnderThreshold MD (CGF) MC	F5	1/1/2014	4/30/2014
1003	FFS2 Under Threshold MD (Can be used for Nurse practitioner for Med Support)	FFS2 UnderThreshold MD Med Svcs Only (Can be used for Nurse practitioner for Med Support)	F8	1/1/2014	12/31/2014
1002	FFS2 Under Threshold non MD	FFS2 Outpt Under Threshold non MD (CGF)	F3	5/1/2014	8/31/2014
1003	FFS2 Under Threshold MD	FFS2 Outpt UnderThreshold MD (CGF) MC	F6	5/1/2014	8/31/2014
1002	FFS2 Under Threshold non MD	FFS2 Outpt Under Threshold non MD (CGF)	F4	9/1/2014	12/31/2014
1003	FFS2 Under Threshold MD	FFS2 Outpt UnderThreshold MD (CGF) MC	F7	9/1/2014	12/31/2014

2. Create admission, Create Financial Eligibility and Create Over Threshold Authorization (Responsible Individual(s) for readiness testing purpose –LAC DMH) :

- a) LAC DMH will create admissions for the provided clients under the program of admission – “x FFS2LE Fee For Service 2 Admission” .
- b) LAC DMH will create the Financial Eligibility for each client as follows.
 1. Medi-Cal 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. Medi-Medi or OHC-Medi-Cal client:

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

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

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

 - (4) Guarantor ID for OHC payer at the discretion of the provider. (See Guarantor Listing) with Plan 5 for Guarantor IDs 20-164

(5) Guarantor ID 10 with Plan ID 1

(6) Guarantor ID 16 with Plan ID 2

- c) LAC DMH will create an Over Threshold Authorization Request (OTAR) and approve.

Upon completion of the setup, the provider must be informed as the setup is complete and should be supplied with the Over Threshold Authorization number.

3. Claiming Cycle 1 Verification (Responsible individual(s)- FFS Provider, LAC DMH):

Following the positive validation of the system setup of the provider, client data and client's Financial Eligibility, the provider will submit one claim for each client using the Funding Source Authorization appropriate (MD or non-MD) based on the discipline of the provider. Please adhere to the following naming convention:

<ProviderInitial>_<DUNSnumber>_837P_Scen_<Scenario Number>_<YYYYMMDD> .txt (e.g. TB_000000000_837P_Scen1_20140201.txt)

- 1) Medi-Cal Client - Financial Eligibility for Medi-Cal (10) and LA County (16).
 - a) Submit a claim with duration and age that is valid to have a payment to the provider using Funding Source Authorization.
 - b) Submit a claim for med support services using the med support Funding Source Authorization.
 - c) Submit an Over Threshold claim with Over Threshold Authorization number provided by LAC DMH.
- 2) Medi-Medi or OHC-Medi-Cal Client.
 - a) Submit a claim with duration and age that is valid to have a payment to the provider using Funding Source Authorization.

Claiming Cycle 1 verification will be considered complete when the provider has submitted an Approved claim for each category above. Upon completion of this step, the provider will be notified about the test status.

4. Claiming Cycle 2 Verification (Responsible Individual(s)- FFS Provider, LAC DMH):

Once the 1st cycle of Provider Claim Readiness has been validated and communicated to the Provider, the provider will submit 2 claims to Void and Replace claims that were submitted in the 1st claim cycle. The Provider will submit claims as follows:

- 1) Void an Approved Claim from Claiming Cycle 1
- 2) Replace a Claim from Claiming Cycle 1 using the duplicate modifier '59'

Claiming Cycle 2 verification will be considered complete when the void - is successfully voided and replacement is approved.