

FFS Claims Certification Testing Script

FFS Provider Claiming Readiness Testing will consist of the following required phases:

- 1) Provider Setup: IBHIS Setup and Testing Verification
- 2) Client Setup: Create Admission and Create Financial Eligibility
- 3) Over Threshold Authorization: Request Authorization and Receive Approval
- 4) Claiming Cycle 1 Verification: Claim Adjudication
- 5) Claiming Cycle 2 Verification: Replacement Claims
- 6) Claiming Cycle 3 Verification: Void Claims

1. IBHIS Setup and Testing Verification (Responsible Individuals: LACDMH and 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 provider’s 835s.
- 3) Use the funding sources listed in the Funding Sources Table at the end of this document.
- 4) Provider to confirm which two clients need to be used for testing. Provider to supply the two IS client IDs 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 and Procedure Code to be used for over threshold claim testing from the provider. This is required to create member based authorization for over threshold authorization request.
- 7) Which client (IS Client ID) to have OHC Guarantor and Provider to supply which OHC guarantor to be used.

2. Create Admission and Financial Eligibility in Provider Connect (Responsible Individual: FFS Provider)

1. Provider will create admissions for the provided clients under the program of admission – “x FFS2LE Fee For Service 2 Admission” in Provider Connect.
2. Provider will create Financial Eligibility in Provider Connect for each client as follows.
 1. Medi-Cal Client: Financial Eligibility set up in Guarantor Order as follows:
 - (1) Medi-Cal
 - (2) LA County
 2. Medi-Medi or OHC-Medi-Cal client:
 - a. For Medi-Medi client, Financial Eligibility set up in Guarantor Order as follows:
 - (1) Medicare
 - (2) Medi-Cal
 - (3) LA County

- b. For OHC-Medi-Cal client, Financial Eligibility set up in Guarantor Order as follows:
 - (1) Guarantor ID for OHC payer at the discretion of the provider. (See list of Guarantors located in the 'Guarantor' dropdown list located in the Financial Eligibility form in Provider Connect.)
 - (2) Medi-Cal
 - (3) LA County

** Detailed instructions for setting up the client and financial eligibility are included in the Provider Connect training document located at the following site:*

http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_homepage.htm

3. Request Over Threshold Authorization in Provider Connect (Responsible Individuals: FFS Provider and LACDMH)

1. The Provider will request an Over Threshold authorization in Provider Connect. When completing the Over Threshold authorization, the Provider will select FFS2 Authorized Outpt Svcs (CGF) MC as the funding source and FFS2 Authorized Outpt Svcs (CGF) MC as the Benefit Plan.
2. LACDMH's Central Authorizations Unit (CAU) will approve the authorization.
3. The Provider will check Provider Connect to determine that LACDMH CAU has approved the authorization.

** Detailed instructions for requesting an authorization in Provider Connect are included in the Provider Connect training document located at the following site:*

http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_homepage.htm

4. Claiming Cycle 1 Verification (Responsible Individuals: FFS Provider and LACDMH)*

Following the validation of the setup of the provider in IBHIS, the client data and client's Financial Eligibility, the provider will submit one claim for each client using the funding source appropriate (MD or non-MD) authorization 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 the funding source authorization. The list of funding source authorizations is included in the Funding Source Authorizations Table at the end of this document.
 - b) Submit a claim for med support services using the med support funding source authorization. The list of funding source authorizations is included in the Funding Source Authorization Table at the end of this document.

- c) Submit an Over Threshold claim with **approved** Over Threshold Authorization number that the provider requested in Provider Connect.
- 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 the funding source authorization. The list of funding source authorizations is included in the Funding Source Authorization Table at the end of this document.

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 of the test status.

** After the client admission and financial eligibility are setup in Provider Connect and the over threshold authorization is approved by LACDMH's CAU, the provider can then begin to submit test claims.*

5. Claiming Cycle 2 Verification: Replacement Claims (Responsible Individuals: FFS Provider and LACDMH)

- 1) Once the 1st cycle of Provider Claim Readiness has been validated and communicated to the Provider, the provider will submit a replacement claim for one of the claims submitted in the 1st claim cycle. The Provider will replace a claim from Claiming Cycle 1 using the duplicate modifier '59'.
- 2) Claiming Cycle 2 verification will be considered complete when the replacement claim is successfully is approved.

6. Claiming Cycle 3 Verification: Void Claims (Responsible Individuals: FFS Provider and LACDMH)

Once the 1st and 2nd cycles of Provider Claim Readiness have been validated and communicated to the Provider, the provider will submit a claim to void one of the claims submitted in the 1st claim cycle. The Provider will void an Approved Claim from Claiming Cycle 1.

Claiming Cycle 3 verification will be considered complete when the claim is successfully voided.

Funding Source Authorizations Table

The following are the 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
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