

## FFS Claims Certification Testing Script

FFS Provider Claiming Readiness Testing consists 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)*

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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 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)*

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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](http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_homepage.htm)

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

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1. The Provider will request an Over Threshold authorization for services in the current trimester period 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. The four month trimester period is as follows: January 1 – April 30, May 1 – August 31, and September 1 – December 31.
3. LACDMH's Central Authorizations Unit (CAU) will approve the authorization.
4. 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](http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_homepage.htm)

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

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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:

FFS\_<ProviderInitial>\_<DUNSnumber>\_837P\_Scen\_<Scenario Number>\_<Sequence Number>\_<YYYYMMDD>.txt (e.g. FFS\_TB\_000000000\_837P\_Scen1\_001\_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 on page 4 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 on page 4 of this document.
  - c) Submit an Over Threshold claim with **approved** Over Threshold Authorization number that the provider requested in Provider Connect in phase 3 of this document.
- 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 on page 4 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)**

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Please adhere to the following file naming convention:

FFS\_<ProviderInitial>\_<DUNSnumber>\_837P\_Scen\_Repace\_59\_YYYYMMDD> .txt (e.g. FFS\_TB\_000000000\_837P\_Scen\_Replace\_59\_20140201.txt)

- 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 1<sup>st</sup> 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)**

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Please adhere to the following file naming convention:

FFS\_<ProviderInitial>\_<DUNSnumber>\_837P\_Scen\_Void\_YYYYMMDD> .txt (e.g. FFS\_TB\_000000000\_837P\_Scen\_Void\_20140201.txt)

Once the 1<sup>st</sup> and 2<sup>nd</sup> 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 1<sup>st</sup> 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.

**Health Care Claim: Professional (837P) 2400/REF02 - Prior Authorization Number**

The IBHIS system requires a valid authorization number for each submitted claim in an 837 file. Please refer to Section 6.1 of the HIPAA 837 Transaction Standard Companion guide for IBHIS for more details. It can be found at: [http://lacdmh.lacounty.gov/hipaa/ffs\\_IBHIS\\_EDI\\_Guides.htm](http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Guides.htm)

**Funding Source Authorizations** are used by Fee-for-Service providers for 8 under threshold sessions per trimester period and medication support services. For testing claims, with the exception of step 1c in Phase 4, Fee-For-Service providers need to use the authorization number from the table below based on the discipline, service type, and service date in the 837 claim file. It is important to note that the system will not allow the submission of test claims with future dates of service, so be sure to include the appropriate Funding Source Authorization Number in all test claims. These authorization numbers begin with an 'F', followed by a number.

Fee-for-Service Funding Source Authorization Table\*

<b>Provider Discipline Type</b>	<b>Service Type</b>	<b>Service Date Between</b>	<b>Authorization Number to use in 837(Claim)</b>
Non MD	Under Threshold	5/1/2014 to 8/31/2014	F3
Non MD	Under Threshold	9/1/2014 to 12/31/2014	F4
Nurse Practitioner	Med Support	1/1/2014 to 12/31/2014	F8
MD	Under Threshold	5/1/2014 to 8/31/2014	F6
MD	Under Threshold	9/1/2014 to 12/31/2014	F7
MD	Med Support	1/1/2014 to 12/31/2014	F8

\*This table is subject to change. Please check the following web site for the latest FFS claims Certification Test Script: [http://lacdmh.lacounty.gov/hipaa/ffs\\_IBHIS\\_EDI\\_Readiness.htm](http://lacdmh.lacounty.gov/hipaa/ffs_IBHIS_EDI_Readiness.htm).

**Member Authorizations** are specific to a client and used by Fee-for-Service providers for specific services and duration of time. For step 1c of Phase 4, Fee-for-Service providers use the approved Over Threshold Authorization number that is generated via the Provider Connect application as part of Phase 3 of this document. Member authorization numbers are all numeric.

**\*Note to FFS Network Billers Representing Multiple Providers**

If you are a FFS network biller providing services to more than one FFS network provider, and you take on the responsibility of performing the testing for all of your providers, you may opt to skip Phases 2, 5, and 6 after you initially complete all Phases for one provider to avoid duplication of work, assuming all providers represented by you use the same instance/version of your claiming system. In other words, you may complete Phases 1 through 6 for one specific provider, and then complete Phases 1, 3, and 4 for the rest of your providers. By doing such, you may be able to use the test clients that you create

during Phase 2 for one provider to complete Phases 3 and 4 for the rest of your providers. If you intend to pursue this approach, please make sure that you send DMH a complete list of all providers that you will be submitting test claims for prior to submitting such test claims. This list must identify the specific provider that you will use to complete Phases 1 through 6, and the providers that you will use to complete only Phases 1, 3, and 4. Please email this list to [srodriguez@dmh.lacounty.gov](mailto:srodriguez@dmh.lacounty.gov).

For FFS Network billers representing multiple providers, the following caveats apply when considering the approach noted above:

1. The provider that you select to complete all six phases of the certification test script must be a provider that can complete the most number of testing scenarios under Phase 4. Please select a provider that you can submit test claims for Medi-Medi or OHC-Medi-Cal clients or medication support, and ensure that you identify such provider in the list that you send to DMH as mentioned above.
2. Phases 1, 3, and 4 must be completed for all providers once you have completed Phases 1 through 6 for one provider as described above.
3. If you represent group and individual providers, all six phases must be completed for one individual provider and one group provider.
4. Service dates on the test claims should be different by provider if you are using the same test clients for all of your providers.
5. It is important **NOT to submit more than 8** under-threshold test claims in a trimester period per test client. Otherwise, the ninth test claim may be denied.