



**CPTP EDI News Bulletin #005
9/22/2008**

**Guideline for Submitting
Corrected Claims**

Attention: All EDI Providers

STOP – Impact on You

The Guideline for Submitting Corrected Claims can improve your revenue process by correcting common denied messages before submitting EDI claims

CAUTION – What You Need to Know

Please see below for some common error message “DENIED” and/or “PENDING” that can be corrected as shown below.

GO – What You Need to Do

1. If the original claim status is “DENIED” due to DMH RULES or CICS violations, what is the proper way to send in the corrected claim?

Send in as an Original (new) claim with a unique submitter ClaimID.

2. If the original claim status is “DENIED” due to “FIN ADJ” at the State level, what is the proper way to send in a corrected claim?

There are several possible scenarios depending upon how you wish to correct the claim.

A. If you **are not** changing the local plan but wish to send a corrected claim back to the State, then simply send in a Replacement claim.

B. If you **are** changing the local plan and sending the corrected claim back to the State, you must send in a Void AND a Replacement claim. See Note 1.

C. If you **are not** changing the local plan and **are not** planning to send a corrected claim to the State (e.g., the client is no longer Medi-Cal eligible), you may choose to do nothing. The County may pay the provider from the local plan indicated on the original claim. However, it might be best practice to send a Void for the original claim and send in a Replacement claim. This may be less confusing in reconciling your claims since you will not have to deal with getting paid on a “denied” claim.

Please also see Note 2 below for further details.



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3. If the original claim status is "PENDING" and we need to fix it for some reason, what type of claim(s) do we send?

First send in a Void, then send in the corrected claim as Original (new).

4. If the original claim status is "FORWARDED" and we need to fix it for some reason, what type of claim(s) do we send?

First send in a Void, then send in the corrected claim as Original (new).

5. If the original claim status is "APPROVED" and we need to fix it for some reason, what type of claim(s) do we send?

First send in a Void, then send in the corrected claim as Original (new).

Note 1: EDI submitters **must void** the first claim if they want to send in a replacement claim with another local plan. If they do not void the first claim and send in a replacement claim with a different local plan, it would be considered as a duplicate and DMH would not be able to catch it. The same claim would be billed twice, hence would be paid twice from two different local plans and/or Medi-Cal (if Medi-Cal approves the replacement claim). If a claim is approved by the State, then it would be paid out of the Medi-Cal allocation; DMH would apply the FMAP (Federal Medical Assistance Percentage) as applicable depending on the type of MC (EPSDT or not).

Note 2: When the IS automatically denies a claim due to a Medi-Cal denial, this sets a status of 'Denied' in the IS and at this time the provider can send in a replacement (claim frequency 7) claim. If the provider does not include Medi-Cal on the subsequent replacement claim – the claim will not go to Medi-Cal.

Here is the step by step detail of the process:

1. Provider sends Claim to IS with Medi-Cal as a payer
2. Claim passes IS Rules and MHMIS edits
3. IS sends claim to Medi-Cal
4. Medi-Cal returns denied 835 to IS
5. IS automatically denies claim since Medi-Cal denies
6. IS sends denied 835 to provider
7. Provider can respond as in scenarios 2A, 2B, or 2C noted above. Note that the IS will only send the claim to Medi-Cal, if Medi-Cal is included in the replacement claim.