

## Billing Guidelines

- a. Verify MAP eligibility and that there is no other payer source (i.e., Medi-Cal, Medicare, Private Insurance, Worker's Compensation, etc.).
- b. Provide the patient's social security number, a copy of the TAR, and any and all documents, which substantiate the claim and help identify the patient. If a surgical procedure was performed, attach a copy of the Operating Report to the claim. If the services were performed in the Mercy Medical Center Merced (MMCM) emergency room, attach a copy of the emergency room record.
- c. Emergency services performed in a facility other than MMCM are not covered by MAP.
- d. For purposes of State reporting, the Medical Assistance Program (MAP) requires that all charges are separated by month of service. Do not put more than one month on a claim form. The claim will be returned for separation before processing. (Inpatient claims are an exception to this requirement.)
- e. All claims submitted for payment to the Medical Assistance Program (MAP) must be submitted on a CMS 1500 or UB92 form.
- f. The Medical Assistance Program (MAP) claims processing system accepts CPT and HCPCS codes for all medicine, surgery, radiology, anesthesiology, evaluation and management, laboratory, and allied health services. To assure timely and accurate processing of claims, appropriate numeric CPT modifiers and alphanumeric HCPCS modifiers must also be used.
- g. To assure prompt payment of By-Report or Unlisted Value claims, attach the following documentation to the claim form:

1. History and Physical
2. Pertinent X-Ray Reports
3. Pertinent Lab Reports
4. Operating or Procedure Reports
5. Discharge Summary

- h. To avoid procedure value reductions due to incomplete reporting, be certain that operating and procedure reports detail the following:

1. A description of the nature and extent of the need for the procedure
2. The time, effort and equipment necessary to provide the service
3. The complexity of symptoms and pertinent physical findings
4. The size, number, and location of lesions (if applicable)
5. Estimated follow-up days required

	6. How the procedure relates to the diagnosis
	7. Concurrent problems, where applicable

I. Include a primary ICD9 diagnosis code. MAP does not accept V or E codes as primary diagnosis codes on In-patient claims.

j. When services are rendered outside Mercy Medical Center Merced (MMCM), make sure a valid referral or treatment authorization request (TAR) exists. Attach a copy of the approved TAR or referral form to the claim and/or write the TAR number on the claim form itself. If the services were not prior authorized, the claim will be denied. If a TAR or referral lacks the appropriate signature of the MAP case manager or his/her designee, the TAR or referral is invalid.

k. Attach a copy of the required TAR for all non-emergent surgeries performed at Mercy Medical Center Merced (MMCM) or elsewhere and write the TAR number on the claim form.

l. Make sure the claim is signed. If using a stamped signature, the provider or billing clerk must also initial next to the stamp. If the provider is unavailable to sign the claim form, it may be signed by his/her authorized designee, i.e. Billing Manager.

m. Submit the claim to the Medical Assistance Program within one hundred and eighty (180) days of the date of service. If greater than one hundred and eighty (180) days has past when first submitting the claim for payment, provide appropriate documentation for waiver of billing limit.

n. The MAP claims processing unit applies a one hundred and eighty (180) days window to all billing transactions unless the claim is submitted with documentation supporting one the following reasons:

1. Waiting for response from other third-party payer source, i.e. Medi-Cal, Worker's Comp, insurance settlement etc. Submit within ninety (90) days or receipt of documentation an Explanation of Benefits (EOB), Remittance Advice (R/A), or other document, which indicates the patient was not eligible and therefore no payment will be made on the patient's behalf.
2. A change in financial class eligibility which was not disclosed in time to bill within the one hundred and eighty (180) day billing limit. Submit documentation such as an MMCM face sheet or other registration form showing original non-MAP financial class. This document must be date stamped by the provider's office on the date of receipt and submitted to MAP within ninety (90) days of that date.
3. Provider computer conversion or billing staff turns over. Advanced notice is required under these circumstances. A letter from the provider stating the reason and anticipated length of the delay is required prior to the one hundred and eighty (180) day billing deadline. Under these circumstances the billing window may be extended for a period not to exceed six (6) months from the date of notification.

o. When resubmitting claims previously denied by the MAP Claims Processing Unit, make sure that the claim is resubmitted within ninety (90) days from the denial and that it is resubmitted on the original claim form, including information and coding essential for accurate and timely adjudication of the resubmitted claim.

p. Under no circumstances, other than Medi-Cal pending disability determination, does the Medical Assistance Program (MAP) pay for claims submitted beyond one (1) year from the date of service. Appeals of denied claims will not be considered if received more than 90 days after recipient of EOB showing detail

q. Claims which are submitted for patients who have been denied Medi-Cal as not disabled will be paid provided the following criteria have been met:

1. The patient had a concurrent MAP certification on file with the aid code of 88 or 89 (MCL pending disability determination) for the specified date of service.
2. The MAP office has received adequate documentation stating the patient was denied Medi-Cal as not disabled. Patients who have been denied as non-compliant will also be denied MAP eligibility. Charges for these services should be billed to the patient as personal pay.
3. The provider requested and received approval on the Treatment Authorization Request (TAR) or referral prior to rendering services.
4. All other billing criteria stated have been met.