Recommended Actions for Accurately Submitting Newborn Encounters

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Executive summary

Newborns are not immediately assigned a Client Index Number (CIN), which is the patient's unique identifier, when they are born. To help with filing claims and encounters for newborns' services, DHCS policy allows newborns to be covered under their mother's CIN for the newborn's birth month as well as the following month. However, managed care plans (MCPs) have been inconsistent in implementing DHCS requirements; not all MCPs accept encounters during

this entire timeframe. For example, some MCPs only accept a newborn's encounters under their mother's CIN for the first thirty days of life. The varying submission guidance from MCPs is due in part to unclear communication from DHCS which causes confusion for MCPs and providers. This confusion directly impacts the timeliness and completeness of encounter data submissions that account for services rendered to newborns who do not yet have a CIN.

The recommended action outlined below intends to standardize MCP submission requirements so that they fully align with DHCS's submission policy for newborns.

Summary of recommendation

Update submission policies for newborns to fully align with state guidelines

Per DHCS's All County Welfare Directors' Letters (ACWDLs) 03-49, newborns are allowed to be billed under their mother's CIN for their birth month as well as the entire following month. For example, if a baby is born on March 28, they are eligible for services under their mother's CIN until April 30.

- **DHCS** should provide and communicate consistent guidelines to MCPs on the appropriate timeframe where newborns can be billed under their mother.
- **MCPs** should review their processes and systems to ensure they are fully aligned with DHCS's policy for billing newborn encounters.
- **Delegates** should review and implement any training required to be compliant with their contracted MCPs' submission requirements.

Overview

Definitions

834 Benefit Enrollment and Maintenance File: Standard file format used for electronically exchanging health plan enrollment data. This file includes member enrollment information, such as new enrollee information, changes to members' enrollment, reinstatement of members' enrollment, and disenrollment of members. There are two versions of this file that are provided by DHCS to an MCP: a monthly file and a daily file.

Client Index Number (CIN): CIN is a unique identifier assigned to an individual by the county in which the client resides. An active CIN indicates Medi-Cal eligibility and is used for billing services rendered for the patient.

Delegate: Any party that has an agreement with a health plan to provide administrative services or healthcare services to qualified individuals, qualified employers, or qualified employees and their dependents.

DHCS Documentation Center: A single source that hosts all DHCS Companion Guides, Schemas, Error Addenda, Technical and Testing Documentation, and other artifacts and documents related to DHCS data standards and data processing systems. Health plans must request permission from DHCS to access the center.

DHCS Medi-Cal Eligibility Data System (MEDS): A statewide data hub serving a variety of eligibility, enrollment, and reporting functions for Medi-Cal and other state and federal benefits.

Issue Background

Per DHCS Medi-Cal Managed Care policy (All County Welfare Directors' Letters (ACWDLs) 03-49), services rendered to newborns may be billed under their mother's Client Index Number (CIN) for the newborn's birth month and the following month (e.g., if a newborn is born April 21, services provided to the newborn may be billed under the mother's CIN until May 31). After that period, services rendered to the newborn must be billed under their own CIN.

Newborn births must be reported to the county to confirm the newborn's eligibility for Medi-Cal services and begin the enrollment process. Once eligibility is confirmed, the county must account for the newborn's birth in DHCS's Medi-Cal Eligibility Data System (MEDS). DHCS then issues the newborn a benefits card that contains their CIN.

Problem Statement

Because newborns are not immediately assigned a CIN at birth, DHCS allows newborns coverage under their mother's CIN for the newborn's birth month as well as the following month. However, managed care plans (MCPs) have been inconsistent in implementing this DHCS requirement, and not all MCPs accept encounters during this entire timeframe. For example, some MCPs only accept newborn encounters billed under their mother's CIN for the first thirty days of life. This causes confusion and directly impacts the timeliness and completeness of encounter data submissions that account for services rendered to newborns who do not yet have a CIN.

Recommended Future State

MCPs should fully adhere to DHCS policy for submitting newborn encounters and allow services rendered to newborns to be billed under their mothers' CIN for newborns' birth month and the following month. This will simplify and standardize the submission process for all stakeholders while fully aligning with regulatory requirements.

Recommended action

Update submission policies for newborns to fully align with state guidelines

Per DHCS's All County Welfare Directors' Letters (ACWDLs) 03-49, the policy explicitly states that newborns are allowed to be billed under their mother's CIN for the birth month and the following month. All documentation, communications, and encounters/claims processing systems should be updated to reflect this policy and be trickled down to the delegated entities that work with newborn claims and encounters. Please note you can always reach out to your health plan or DHCS representative for the latest version of the "DHCS Encounter Data Reporting: Mother and Newborn Coding Guidance".

Stakeholder-specific recommendations

Organizations are recommended to follow the listed procedures below.

DHCS should review all existing documentation to ensure newborn guidance is appropriately stated. This includes internal and external facing documents, such as documents that are provided to MCPs to support encounter data submissions as well as information communicated in MCP webinars. Updated documents should also be made available in the DHCS Documentation Center that is available for managed care plan access.

MCPs should review their internal processes to ensure that they are compliant with DHCS policy for newborn submissions. If MCPs' processes are not in alignment with DHCS policy, plans should update submission policies and processing system logic to follow DHCS guidance. Plans should also update provider submission guides and communicate the updates to their delegated entities.

Delegates should review their internal processes to ensure alignment with updated encounter submission guidelines. If the updated guidance is different than the current process, delegates should work with staff to provide training on updated procedures, especially for those who work directly with servicing and billing for newborn encounters.

Additional recommended actions

Standardize inbound submission requirements

Consistent formatting requirements for providers would help streamline the process to submit newborn encounters which would lead to more accurate, complete, and timely submissions. It would also lead to fewer duplicated or denied encounters.

Stakeholder-specific recommendations

DHCS should continue to adhere to their submission requirements as listed in the DHCS 837 Standard Companion Guide (CG) Transaction Information (Institutional and Professional). DHCS's CG specifies that Medi-Cal views each beneficiary as an individual subscriber so information in the patient loop (2010CA) is not accessed. DHCS tells plans that they are not required to send the patient loop in their encounters, including those for newborn encounters; therefore, plans should submit newborn encounters utilizing the subscriber loop to DHCS.

MCPs should refer to the following for their inbound and outbound processes.

- Inbound expectations (submission to the health plan): health plans should align to create a common format for providers to submit newborn encounters for newborns not yet enrolled with a plan. It is recommended that plans allow newborn encounters in two formats when the newborn is not yet enrolled in a specific plan (see details and an example in Appendix A):
    - Newborn can be submitted as the subscriber in the loop 2010BA (Subscriber Name) and using the mother's CIN (*preferred*)

  OR

    - Newborn can be submitted as a dependent to the subscriber (mom) in the loop 2000C (Patient Info)
- Outbound expectations (submission to the regulator (DHCS)): health plans should organize their outbound systems to be able to submit newborn encounters without the patient loop included when sending to DHCS.

Delegates should review the prescribed formatting and work with their health plans to ensure newborn encounters will be accepted under these formats. Delegates should provide training or documentation for their billing staff to ensure clear guidelines for newborn encounters are understood by staff.

Leverage eligibility reports to confirm newborn enrollment

Health plan eligibility reports are a key component to tracking whether a patient is enrolled and eligible to receive services. Eligibility reports are especially important for newborns who have coverage for a limited amount of time – only for their birth month and the following month – under their mother's insurance coverage. Having access to up-to-date eligibility reports and CINs will inform providers whether a newborn's services can be billed under the newborn or its mother.

DHCS provides MCPs with monthly and daily 834 Benefit Enrollment and Maintenance files (834 files) which provide up-to-date membership information. The monthly file, often distributed near the end of the month, includes all members who are eligible to receive services within a specific plan; the daily files provide updates made to member information in the MEDS system, including the addition of new members receiving services within the health plan. This means that the daily file is important for MCPs to understand when a newborn becomes eligible for services under a health plan; the newborn eligibility information is then also added to the next iteration of the monthly 834 file. Both the monthly and daily 834 files assign members with a health plan code (HCP) status code 'B1' to indicate that the beneficiary is a recently born infant and will be covered under the mother's coverage until the infant has established coverage.

This information gets translated by the health plans and is then communicated back to the delegates on a non-standard frequency. The frequency is dependent on the capabilities of both the plans as well as the delegate's enrollment teams.

Stakeholder-specific recommendations

DHCS should continue to release an 834 Benefit Enrollment and Maintenance file to plans on two separate schedules: monthly and daily.

MCPs should work with their delegates to establish a standard frequency to share enrollment updates that will identify newborns and their enrollment status.

Delegates should leverage eligibility reports transmitted from MCPs to confirm newborn enrollment when scheduling and providing services by checking for a status code of 'B1' in the 834 files as described above.

Educational opportunities for providers

Provider education is a key component to ensuring policies are properly implemented and adhered to at the start of the submission process. Proper submissions will lead to more accurate and timely encounter data quality. Educational opportunities for providers are listed below:

- Providers should have staff confirm eligibility prior to scheduling newborn visits. Providers should check and confirm eligibility using DHCS MEDS.

- If the newborn is currently not enrolled and is outside of the allowed timeframe where their services are covered by their mother's insurance, then the provider can encourage the patient to apply for presumptive eligibility, which would allow for immediate, temporary care at no cost to the individual while they are applying for permanent Medi-Cal or other health coverage (e.g., the mother could bring the newborn in for an emergency room visit without coverage and still be able to receive full services). For additional details on presumptive eligibility, please refer to the DHCS Medi-Cal Eligibility Programs Page.
- Providers or facilities should encourage patients to enroll newborns as soon as possible to ensure they are assigned a CIN in a timely manner. For reference, parents have up to 1 year to enroll their newborn into Medi-Cal for services rendered or to receive retroactive coverage starting from the month when they lost coverage.

Program Background

As part of Health Net's Encounter Data Improvement Program, IHA serves as the Encounter Data Governance Entity (EDGE) and is charged with coordinating encounter data improvement efforts across California.

Within IHA's multi-pronged approach to move the needle on encounter data, IHA has established a Data Standards Implementation workstream to work directly with stakeholders to develop recommended actions. These actions are intended to improve encounter data quality across six priority areas within encounter data submission as identified during the 2020 Health Net Manatt Encounter Data Summit.

Priority areas identified at the 2020 Health Net Manatt Encounter Data Summit
Duplicate encounters
Tracing errors to their sources
Newborn identification
Communicating rejections and remediation
Visit-Encounter reconciliation
Use of local codes

Participants of the Data Standardization Workshop that occurred at the 2020 Encounter Data Summit established newborn identification in an encounter submission was an issue that would lead to rejections due to being a duplicate to the mothers' encounter. This issue impacts timely submission since the delegate has to go back and correct newborn encounters before resubmitting to the health plan. Timely correction and resubmission directly impact encounter data throughput to DHCS.

To create recommended actions intended to streamline submission requirements for newborn services, the Data Standards Implementation (DS) Workstream partnered with the Health Industry Collaboration Effort (HICE) and their Encounters Standardization Team (HICE Encounters Team), a voluntary group that convenes weekly to review, problem-solve, and analyze encounter data issues to improve processes through the industry. To fully understand the scope of the issue, members of the HICE Encounters Team shared their processes with how they submit newborn encounters and guidelines they follow to process newborn services. The goal was to align guidelines for newborn eligibility requirements which would be communicated and implemented for providers by health plans. DS and HICE

Encounters Team then finalized the recommended actions and identified other opportunities to enhance the newborn encounter submission processes for delegates and health plans.

Appendix A: Best Practice for Newborn Submissions

This guidance is for provider use for the Medi-Cal line of business. Please confirm with your contracted health plan if this is an acceptable format for other lines of business.

Guidelines state that newborn services can be billed under their mother's CIN in Medi-Cal for their birth month and the following month. After this timeframe, newborn services must be billed under their own CIN.

Example: newborn is not eligible or enrolled in the health plan and within the appropriate timeframe

Option 1 (*recommended*)

Newborns can be submitted as a subscriber using loop 2010BA (Subscriber Name) with the mother's CIN in the Loop 2010BA, NM109 (ID Code) field.

See a sample 837 format:

> *HL*2*1*22*1~*
> *SBR*S**1145A******HM~*
> *NM1*IL*1* Newborn Last Name*Newborn First Name****MI*Subscriber ID (Mother's id) ~*
> *N3*100 DOWNTOWN RD~*
> *N4*ELK GROVE*CA*922209999~*
> *DMG*D8*Newborn DOB*Newborn Gender type~*
> *CLM*12340*100***13>B>1*Y*A*Y*Y~*
> *LX*1~*
> *DTP*472*D8*Date of Service~*

Option 2

Newborns can be submitted as a dependent using the following:

- Patient Hierarchical Level: loop 2000C, segment PAT using code 19 (PAT*19) to indicate the individual relationship segment (child/dependent)
- Patient name: loop 2010CA to submit newborn information, such as name, date of birth, and demographics
- Subscriber name: loop 2010BA to submit mother information

See a sample 837 format:

> *HL*2*1*22*1~*
> *SBR*S**1145A******HM~*
> *NM1*IL*1*Subscriber Last Name*Subscriber First Name****MI*Subscriber ID ~*
> *NM1*PR*2*HEALTH NET*****PI* 954402957~*
> *HL*3*2*23*0~*
> ***PAT*19~***
> ***NM1*QC**1*Newborn Last Name* Newborn First Name ~*

> *N3*100 DOWNTOWN RD~*
> *N4*ELK GROVE*CA*922209999~*
> *DMG*D8*Newborn DOB*Newborn Gender type~*
> *CLM*12340*100***13>B>1*Y*A*Y*Y~*
> *LX*1~*
> *DTP*472*D8*Date of Service~*

Example: newborn is eligible/enrolled with the health plan with their own CIN

Example 1

Newborn can be submitted as the subscriber using loop 2010BA (Subscriber Name) in the NM1 segment.

See a sample 837 format:

> *HL*2*1*22*1~*
> *SBR*S**1145A******HM~*
> *NM1*IL*1*Subscriber Last Name*Subscriber First Name****MI*Subscriber ID~*
> *N3*100 DOWNTOWN RD~*
> *N4*ELK GROVE*CA*922209999~*
> *DMG*D8*Subscriber DOB*Subscriber Gender type~*
> *CLM*12340*100***13>B>1*Y*A*Y*Y~*
> *LX*1~*
> *DTP*472*D8*Date of Service~*