

Code Correlations: Delay Reason Codes (Formerly Billing Limit Exception Indicators)

Medi-Cal has developed administrative code set correlation tables for provider use to begin to prepare for business and billing operation changes, software and practice management system modification and vendor or clearinghouse use. Additional policy, billing instructions and provider manual replacement pages will be included in future *Medi-Cal Updates*. These correlation tables are separated by claim type and billing media (paper, current proprietary and non-standard formats as well as the HIPAA standard formats). These values are not to be used for billing purposes for dates of service prior to September 22, 2003. The correlation tables apply to both paper and electronic claims submission, with each billing medium and table being represented separately. Information for this code set is provided for the following billing media:

- ❖ Long Term Care (25-1), Medical (HCFA 1500 and Vision (45-1) Paper Claims)
- ❖ Inpatient and Outpatient (UB-92) Paper Claims
- ❖ Version 4 Flat File, CMC Proprietary and ANSI ASC X12N 837 version 3041
- ❖ ANSI ASC X12N 837 version 4010A1 (Long Term Care, Medical and Vision)
- ❖ ANSI ASC X12N 837I version 4010A1 (Inpatient and Outpatient)

Code Set: Delay Reason Codes

Billing Media: Long Term Care (25-1), Medical (HCFA 1500) and Vision (45-1) Paper Claims

Modifications for billing:

- Long Term Care (25-1): Field #11 – Billing Limit
- Medical (HCFA 1500): Field #24J – Billing Limit Exception
- Vision (45-1): Field #9 – Billing Limit

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- For Long Term Care claims, the national delay reason codes will replace the current Medi-Cal billing limit exception codes billed in field #11 on the 25-1. This field occurs once for each of six possible recipients on the claim form. In cases where the national value is two digits, the value must be inserted in and adjacent to the single-digit field (#11). A billing example illustrating this requirement will be developed and published in a *Medi-Cal Update* prior to the implementation date.
- For Medical paper claims, the national delay reason codes will replace the current Medi-Cal billing limit exception codes billed in field #24J on the HCFA 1500 claim form.
- For Vision paper claims, the national delay reason codes will replace the current Medi-Cal billing limit exception codes billed in field #9 on the 45-1 Vision paper claim form. In cases where the national value is two digits, the value must be inserted in and adjacent to the single-digit field (#9). A billing example illustrating this requirement will be developed and published in a *Medi-Cal Update* prior to the implementation date.
- The following correlation shows the national value for this field to be used when completing a claim with a beginning date of service on or after September, 22, 2003.
- When completing a claim with a beginning date of service before September, 22, 2003, the current Medi-Cal code must be used.
- The following correlation is in Medi-Cal Current Code value order.

DELAY REASON CODE (BILLING LIMIT EXCEPTION INDICATOR)			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
1	POE unknown	1	POE unknown or unavailable
2	Medicare/Other Coverage	7	Third Party Processing Delay
3	TAR approval delay	3	Authorization Delays
4	Delay by DHCS in certifying providers or by EDS in supplying billing forms	4	Delay in Certifying Provider
		5	Delay in Supplying Billing Forms
5	Delay in delivery of custom-made eye appliances	6	Delay in delivery of custom-made appliances
6	Fire, Flood, Disaster	15	Natural Disaster – in X12 standard (not implementation guide)
7	Theft, Sabotage	11	Other Attachment <i>Indicator must be checked as this option requires attachments.</i>
8	Decisions, Appeals	10	Administrative Delay in Prior Approval Process
A	After 6 month/No reason	11	Other

Bolded items denote changes to previously used values.

Code Set: Delay Reason Codes
Billing Media: Inpatient and Outpatient (UB-92) Paper Claims

Modifications for billing: Field Locator (FL) 31

- The delay reason code (billing limit exception indicator) values used in Medi-Cal billing will no longer be inserted in the condition codes FL 24-30 for paper but instead will be inserted into FL 31.

Billing information:

- Claims currently required to be billed on paper are still required to be billed on paper at this time.
- The following correlation shows the national value for this field to be used when completing a claim for beginning date of service on or after September 22, 2003.
- When completing a claim for beginning date of service before September 22, 2003, the current Medi-Cal code must be used.
- The following correlation is in Medi-Cal current code value order.

DELAY REASON CODE (BILLING LIMIT EXCEPTION INDICATOR)			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
X1	POE unknown	1	POE unknown or unavailable
X2	Medicare/Other Coverage	7	Third Party Processing Delay
X3	TAR approval delay	3	Authorization Delays
X4	Delay by DHCS in certifying providers or by EDS in supplying billing forms	4	Delay in Certifying Provider
		5	Delay in Supplying Billing Forms
X5	Delay in delivery of custom-made eye appliances	6	Delay in delivery of custom-made appliances
X6	Fire, Flood, Disaster	15	Natural Disaster – in X12 standard (not implementation guide)
X7	Theft, Sabotage	11	Other <i>Attachment Indicator must be checked as this option requires attachments.</i>
X8	Decisions, Appeals	10	Administrative Delay in Prior Approval Process
X9	Late Charges (Inpatient Only)	11	Other <i>The third character of Type of Bill (Claim Frequency) must be "5".</i>
X0	After 6 month/No reason	11	Other

Bolded items denote changes to previously used values.

Code Set: Delay Reason Codes

Billing Media: Inpatient and Outpatient Version 4 Flat File, CMC Proprietary (CMC 02, 03, 04, 05, 07) and ANSI ASC X12 837 Version 3041 (Inpatient, Outpatient and Medical)

Modifications for billing:

- Version 4 Flat File: Record Type 41, Field 4-13 – Condition Code
- CMC Proprietary: Billing Limit Exception (Remark)
- ANSI ASC X12 837 v.3041: Loop 2300, K3 – Billing Limit

Billing information:

- The billing limit exception indicator values used in Medi-Cal billing will continue to be inserted in the condition code field for the Version 4 Flat File Format (Record Type 41, Field # 4-13).
- The billing limit exception indicator values used in Medi-Cal billing will continue to be inserted in the remarks Record 6 of the CMC Proprietary Formats.
- The billing limit exception indicator values used in Medi-Cal billing will continue to be inserted in the “K3” field of the ANSI ASC X12 837 version 3041 format.
- The Medi-Cal interim (local) values used for billing limit exception indicators for the Inpatient and Outpatient Version 4 Flat File, CMC Proprietary (all claim types) and ANSI ASC X12 version 3041 format will continue to be used for all dates of service.

Code Set: Delay Reason Codes

Billing Media: ANSI ASC X12N 837 Version 4010A1 (Long Term Care, Medical and Vision)

Modifications for Billing: Loop 2300, CLM20 – Delay Reason Code

Billing information:

- The following correlation shows the national value for this field to be used when completing a claim for beginning date of service on or after September, 22, 2003.
- When completing a claim for beginning date of service before September 22, 2003, the Medi-Cal interim (local) codes must be used.
- The following correlation is in Medi-Cal current code value order.

DELAY REASON CODE (BILLING LIMIT EXCEPTION INDICATOR)			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
1 [^]	POE unknown	1	POE unknown or unavailable
2 [*]	Medicare/Other Coverage	7	Third Party Processing Delay
3	TAR approval delay	3	Authorization Delays
4	Delay by DHCS in certifying providers or by EDS in supplying billing forms	4	Delay in Certifying Provider
		5	Delay in Supplying Billing Forms
5	Delay in delivery of custom-made eye appliances	6	Delay in delivery of custom-made appliances
6 [*]	Fire, Flood, Disaster	15	Natural Disaster – in X12 standard (not implementation guide)
7 [*]	Theft, Sabotage	11	Other <i>Attachment Indicator must be checked as this option requires attachments.</i>
8 [*]	Decisions, Appeals	10	Administrative Delay in Prior Approval Process
A	After 6 month/No reason	11	Other

* Asterisked Billing Limit Exception/Delay Reasons cannot be billed electronically at this time due to paper attachment requirements.

[^] Claims for Share of Cost Reimbursement must be billed on paper.

Bolded items denote changes to previously used values.

Code Set: Delay Reason Codes

Billing Media: ANSI ASC X12N 837I Version 4010A1 (Inpatient and Outpatient)

Modifications for billing: Loop 2300, CLM20 – Delay Reason Code

Billing information:

- The following correlation shows the national value for this field to be used when completing a claim for beginning date of service on or after September 22, 2003.
- When completing a claim for beginning date of service before September 22, 2003, the Medi-Cal interim (local) codes must be used.
- The following correlation is in Medi-Cal current code value order.

DELAY REASON CODE (BILLING LIMIT EXCEPTION INDICATOR)			
CURRENT VALUE	DESCRIPTION	NATIONAL VALUE	DESCRIPTION
X1^	POE unknown	1	POE unknown or unavailable
X2*	Medicare/Other Coverage	7	Third Party Processing Delay
X3	TAR approval delay	3	Authorization Delays
X4	Delay by DHCS in certifying providers or by EDS in supplying billing forms	4	Delay in Certifying Provider
		5	Delay in Supplying Billing Forms
X5	Delay in delivery of custom-made eye appliances	6	Delay in delivery of custom-made appliances
X6*	Fire, Flood, Disaster	15	Natural Disaster – in X12 standard (not implementation guide)
X7*	Theft, Sabotage	11	Other Attachment Indicator must be checked as this option requires attachments.
X8*	Decisions, Appeals	10	Administrative Delay in Prior Approval Process
X9	Late Charges (Inpatient Only)	11	Other The third character of Type of Bill (Claim Frequency must be "5".
X0	After 6 month/No reason	11	Other

* Asterisked Billing Limit Exception/Delay Reasons cannot be billed electronically at this time due to paper attachment requirements.

^ Claims for Share of Cost Reimbursement must be billed on paper.

Bolded items denote changes to previously used values.