



Scan for successfully
billed JI codes

CalAIM Justice-Involved Billing Best Practices

CalAIM Justice-Involved (JI) 90 Day Reentry Initiative

For Providers/Pre-Release Care Coordinators

1 JI Aid Code Activation

When activating the JI aid code, set the effective date to the incarceration date when it falls within the current month. If the incarceration date was in a prior month, set the effective date to the first day of the current month.

Why it matters: Billing depends on the JI aid code being active on the date of service. Using the earliest allowable effective date can help preserve billable days and reduce missed reimbursement, while avoiding activation dates that the portal may not allow.

2 JI Aid Code Termination

When terminating the JI aid code, only add an expected release date if the individual will be definitively released from the correctional facility.

Why it matters: The JI Aid Portal is programmed to terminate an individual's JI aid code on the expected release date, if one is added. However, if it takes longer for the individual to be released from the correctional facility, there will be a gap in service and loss of opportunity for reimbursement.

3 Documentation

Document at a minimum the service provided, purpose of the service, date, provider name and credential, and time, if applicable. It is also helpful to clearly note the care management bundle associated with the service. Different services may require additional documentation.

Why it matters: Billers will likely rely on documentation without having the full program context. Clear notes reduce miscoding and help support claims review and audits.

4 Documentation Timeliness

Complete chart notes as close to the date of service as possible to avoid billing delays and reduce the risk of missing or incomplete documentation. Make sure the time and date of service are recorded, if not already captured by the electronic health record (EHR). If notes are entered retroactively, indicate that clearly.

Why it matters: Timely documentation helps reduce billing delays and follow-up questions, supports more accurate service records, and strengthens the documentation if the claim is later reviewed or audited.

5 Same Day Services

For the same service performed more than once on the same day, document why each instance was medically necessary and, when possible, the different times the service was performed.

Why it matters: Same-day repeat services may trigger denials if supporting documentation or remarks is not provided. Clear documentation helps show that each service was medically necessary, distinct, and not a duplicate entry.

6 Provider Role

Make clear who performed the service and, when applicable, who supervised or oversaw it. If the EHR already captures provider name and credential, confirm that the note still identifies the service clearly enough for billing review.

Why it matters: Claims may depend on the provider type, supervising provider, or enrolled billing provider. Clear role documentation helps billing teams connect the service to the appropriate claiming code.

For Program Administrators

BEST PRACTICE

1 Roles and Responsibilities

Define clear roles and responsibilities for JI aid code activation, eligibility checks, provider enrollment, documentation review, claim submission, denial follow-up, escalation to the Department of Health Care Services (DHCS) or Gainwell Technologies (the third-party administrator for Medi-Cal billing), and other activities needed to support smooth and compliant operations. Ensure all stakeholders understand their responsibilities and when coordination or escalation is needed.

2 Provider Enrollment

Ensure that applicable providers are enrolled in the Provider Application and Validation for Enrollment (PAVE) portal. Based on current understanding, registered nurses (RNs) and lower-level staff cannot be individually registered in PAVE, but services should be linked to the appropriate enrolled supervising or billing provider on site at the time of service.

3 Issue Tracking

Maintain a shared tracker for unresolved operations or billing questions, tentative guidance, denials, system issues, and items needing DHCS or Gainwell clarification.

4 Billing Audits

Regularly audit billed claims against the underlying documentation to confirm that the codes billed are accurate, supported by the documentation, and compliant with billing requirements.

5 Revenue Monitoring

Review remittance advice, Remittance Advice Details (RAD) codes, denials, paid claims, and possible overpayments on a regular cadence.

WHY IT MATTERS

Successful JI operations and billing requires coordination across clinical, eligibility, administrative, and billing functions. Gaps in ownership can lead to missed activations, missed claims, or noncompliance.

Claims may be denied if the supervising/rendering provider associated with the service is not enrolled or recognized correctly in PAVE.

JI operations and billing guidance are still evolving. Tracking open questions helps prevent tentative guidance from being treated as final policy and provides visibility into areas where guidance may change.

Routine auditing helps identify documentation gaps, coding issues, eligibility timing problems, provider setup issues, and billing patterns that may not be visible from individual claims alone. It also helps ensure services are billed appropriately and supports readiness for future claim review or audit.

Regular revenue monitoring helps program administrators understand whether services are being billed and reimbursed as expected and identify patterns that may require follow-up, such as recurring denials, underpayments, overpayments, or workflow issues.

For Billers

BEST PRACTICE

1 Same Day Billing Review

For same-day repeat services, confirm whether documentation supports separate medically necessary services and whether the claim needs remarks, modifiers, or other support.

2 NCCI and Modifier Review

Review applicable National Correct Coding Initiative (NCCI) edits and modifier rules when services are billed together or repeated. Confirm whether a modifier is needed, and if a modifier is used, confirm the documentation supports the distinct nature of the service.

3 Timely Follow-Up

Ensure timely review of and follow-up action on denied or pending claims. Use Claims Inquiry Forms (CIFs), appeals, Gainwell follow-up, or other available processes as appropriate to preserve timely filing options.

4 Provider Enrollment

Confirm that the supervising, rendering, billing, or Ordering, Referring, and Prescribing (ORP) provider associated with the claim is enrolled or recognized appropriately for the service being billed.

5 Revenue Monitoring

Review remittance advice, RAD codes, denials, paid claims, and possible overpayments in a regular cadence.

WHY IT MATTERS

Same-day services may be denied as duplicative if the claim does not clearly show why multiple services were medically necessary on the same date.

NCCI edits and modifier requirements can affect whether services billed together are payable. Reviewing these rules helps prevent avoidable denials, incorrect payments, and billing practices that may create compliance risk.

Delays in follow-up can limit the County's ability to correct and resubmit otherwise billable claims within timely filing requirements. Recurring denials or pending claims may also signal broader workflow, documentation, or system issues that should be identified and addressed promptly.

Claims may be denied if the provider linked to the service is not set up correctly in PAVE or is not recognized in the required provider role.

Revenue integrity is an ongoing function, not only a billing submission task. Payment patterns can reveal documentation, configuration, or system issues.