

# Medi-Cal Provider Training 2016

## Basic Billing







The Outreach and Education team includes Regional Representatives, the Small Provider Billing Unit (SPBU) and Coordinators who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment.

The Medi-Cal Learning Portal (MLP) brings Medi-Cal learning tools into the 21<sup>st</sup> Century. Simply complete a one-time registration to gain access to the MLP's easy-to-use resources. View online tutorials, live and recorded webinars from the convenience of your own office and register for provider training seminars. For more information call the Telephone Service Center (TSC) at 1-800-541-5555 or go to the MLP at <http://www.medi-cal.ca.gov/education.asp>.

## **Free Services for Providers**

### **Provider Seminars and Webinars**

Provider training seminars and webinars offer basic and advanced billing courses for all provider types. Seminars are held throughout California and provide billing assistance services at the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative.

### **Regional Representatives**

The 24 Regional Representatives live and work in cities throughout California and are ready to visit providers at their office to assist with billing needs or provide training to office staff.

### **Small Provider Billing Unit**

The four SPBU Specialists are dedicated to providing one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the SPBU Billing Assistance and Training Program, call 916-636-1275 or 1-800-541-5555.

**All of the aforementioned services are available to providers at no cost!**



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# Recipient Eligibility

## Introduction

### Purpose

The purpose of this module is to provide an overview of the Medi-Cal recipient identification and eligibility verification process.

### Module Objectives

- Review eligibility terminology
- Identify and define the Benefits Identification Card (BIC)
- Identify the functions available in the Point of Service (POS) network
- Review eligibility verification, Medi-Service reservation response information and Share of Cost (SOC)

### Resource Information

#### **Medi-Cal Subscription Service (MCSS)**

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at ([www.medi-cal.ca.gov/mcss](http://www.medi-cal.ca.gov/mcss)).

#### **References**

The following reference materials provide Medi-Cal program, eligibility, billing and policy information.

#### **Provider Manual References**

##### Part 1

*AEVS – General Instructions* (aev gen)  
*AEVS – Transactions* (aev trn)  
*Aid Codes Master Chart* (aid codes)  
*Eligibility: Recipient Identification* (elig rec)  
*Eligibility: Recipient Identification Cards* (elig rec crd)  
*MCP: Code Directory* (mcp code dir)  
*Other Health Coverage (OHC) Codes Chart* (other)  
*Share of Cost (SOC)* (share)

##### Part 2

*California Children's Services (CCS) Program* (cal child)  
*California Children's Services (CCS) Program Eligibility* (cal child elig)

## 2 Recipient Eligibility

### Other References

POS and Internet user guides  
Eligibility Web Tutorial

### Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

# Recipient Eligibility Terms

This module addresses POS device and Internet eligibility transactions. As required by Health Insurance Portability and Accountability Act (HIPAA) electronic standards, the POS network and Internet eligibility transactions include the following terminology:

Provider Manual Terminology	POS Network and Electronic Transaction Terminology
Date of Birth	Subscriber Birth Date
Date of Card Issue	Issue Date
Date of Service	Service Date
Eligibility Verification Number	Trace Number (Eligibility Verification Confirmation [EVC] Number)
First Name	Subscriber First Name
Last Name	Subscriber Last Name
Medi-Services	Medical Services Reservation
Provider Number	Medicaid Provider Number
Recipient	Subscriber
Recipient ID	Subscriber ID
Share of Cost (SOC)	Spend Down Amount (or SOC)

### NOTES

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# Benefits Identification Card

## BIC Overview

The Department of Health Care Services (DHCS) issues a plastic Benefits Identification Card (BIC) to each Medi-Cal recipient for identification purposes.

The BIC is used to access the Medi-Cal Automated Eligibility Verification System (AEVS) to determine a recipient’s eligibility and scope of benefits. It is the provider’s responsibility to verify that the person is eligible for services, and is the individual to whom the card was issued prior to rendering services or goods to that individual.

The BIC is composed of a nine-character Client Identification Number (CIN), a check digit and a four-digit date that matches the date of issue. The BIC issue date is used to deactivate a card when reported as lost or stolen.

Below are two valid BIC samples. The new design, featuring the California poppy, will be provided to newly eligible recipients and recipients requesting replacement cards. There are no plans to provide the new card to the entire Medi-Cal population.



Providers should accept both BIC designs. Providers must continue to verify eligibility. Possession of a Medi-Cal BIC does not guarantee eligibility.

**NOTE**

For policy information about the BIC and verification of eligibility of other programs such as California Children’s Services (CCS) or Genetically Handicapped Persons Program (GHPP), please refer to the appropriate sections of the provider manual.

**NOTES**

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## Temporary Paper Medi-Cal ID Cards

Some recipients are issued temporary paper Medi-Cal ID cards. The paper card is used to identify immediate need eligibility for Medi-Cal and Minor Consent Program recipients. The card contains a 14-digit BIC ID number and is used just like a plastic BIC.

County welfare departments issue temporary paper identification cards to the following people:

- Recipients new to Medi-Cal who have an immediate need for health care services
- Recipients currently eligible for Medi-Cal who have an immediate need for replacement ID card
- Eligible minors who wish to receive confidential care for services

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*****
*                               STATE OF CALIFORNIA                               *
*                               TEMPORARY BENEFITS IDENTIFICATION CARD           *
*                               =====                                       *
*                               ===  FOR IDENTIFICATION PURPOSES ONLY  ===       *
*                               ===  PROVIDER: PLEASE VERIFY ELIGIBILITY  ===     *
*                               =====                                       *
* ID NO. BICIDNUMBERXXX                               ISSUE DATE: MM/DD/YYYY *
*                                                    GOOD THRU : MM/DD/YYYY *
* FIRSTNAME I LASTNAME APL                               *
* F MM/DD/YYYY                                         *
*                                                    *
* SIGNATURE _____                               *
*                                                    *
* TERMVTAMCICSTRANYYYYMMDDHHMMSSDDDOPRXXXXDISWRKR *
*****
  
```

**Sample Paper ID Card for Immediate Need and Minor Consent Recipients.**  
 (Actual card size = 8½ x 11 inches.)

**NOTE**

The ID number is the 14-character BIC ID. State law prohibits use of Social Security Numbers (SSNs) on identification cards.

The bottom line is system information that identifies the source of the card request.

## Share of Cost

Some Medi-Cal recipients may be required to pay a portion of their medical expenses before Medi-Cal will reimburse providers for services. This portion is known as Share of Cost (SOC), or spend down amount.

Recipient SOC amounts vary according to income and dependents. This information is determined by the County Welfare Department.

CCS clients who are also Medi-Cal recipients may pay portions of their SOC during the month until their total SOC has been met. Until the SOC is met, these clients are considered CCS-only clients. Once the SOC has been met, they are considered CCS clients/Medi-Cal recipients.

## Aid Codes

Aid codes help providers identify the types of services for which Medi-Cal and Public Health Program recipients are eligible. A recipient may have more than one aid code, and may be eligible for multiple programs and services. The full chart of aid codes is located in Part 1 of the Medi-Cal Provider Manual. The *Aid Codes Master Chart* (aid codes) was developed for use in conjunction with the Medi-Cal Automated Eligibility Verification System (AEVS). Providers must submit an inquiry to AEVS to verify a recipient's eligibility for services.

## County Codes

Medi-Cal recipients enrolled in contracting Managed Care Plans (MCPs) must receive Medi-Cal benefits from plan providers and not from providers who bill through the fee-for-service program. Each MCP is unique in its billing and service procedures. Providers must contact the individual plan for billing instructions.

The MCP code directory in the Part 1 provider manual includes MCP information for counties that offer Medi-Cal benefits to recipients enrolled in a managed care plan. The directory lists health care plan (HCP) names, codes, addresses, telephone numbers and counties of operation.

## CCS Client Eligibility Verification Process

It is important that providers always verify a CCS client's eligibility for every encounter prior to rendering services.

All providers are expected to use the Medi-Cal identification number from the recipient's BIC or temporary paper Medi-Cal ID card when verifying eligibility, billing Medi-Cal, CCS or submitting Service Authorization Requests (SARs).

### **BILLING NOTICE**

Most providers may no longer bill Medi-Cal, CCS or the Child Health and Disability Prevention (CHDP) program using a recipient's Social Security Number (SSN). Claims submitted with a recipient's SSN will be denied.

## Benefits Identification Card (BIC) for CCS Clients

Possession of a BIC is not proof of CCS or Medi-Cal eligibility. It is a permanent form of identification and is retained by the client even if he or she is not eligible for the current or subsequent months. Providers must verify a client's eligibility before rendering services or goods.

For a sample of a BIC, please see page 3 of this module.

The BIC is for identification purposes only. When using the BIC in conjunction with the Medi-Cal POS network, the following information can be identified:

- Recipient Eligibility
- Share of Cost (SOC) (spend down amount)
- Other Health Coverage (OHC)/Medicare
- Aid Codes
- Medi-Cal Managed Care Plans (MCP)

Children eligible for CCS are identified by aid codes unique to the CCS program. For aid codes and associated messages, refer to the *Aid Codes Master Chart* (aid codes) section in the Part 1 Medi-Cal Program and Eligibility provider manual.

## Medi-Service (Medical Services) Reservation

The POS network is also used to complete a Medi-Service reservation or reversal transaction. Medi-Cal recipients are normally allowed two Medi-Service visits per month. When providers complete a Medi-Service reservation on the POS network, the date of service and the appropriate five-digit procedure code will be required.

Medi-Services are used by Allied Health, Medical Services and Outpatient providers. A Medi-Service should be reserved before billing for the following services:

- Acupuncture
- Audiology
- Chiropractic
- Occupational Therapy
- Podiatry
- Psychology
- Speech Pathology

Providers should not reserve a Medi-Service unless they are certain the service will be rendered. Providers who do not provide a Medi-Service that has been reserved must reverse the reservation to allow the recipient to obtain another service.

**Brainteaser**

1. The SOC can change from month to month. True  False
2. When can the provider waive the SOC?
  - a. Once a week
  - b. Once a month
  - c. Never
3. How does a provider clear a collected or obligated SOC amount?

Answer Key: 1) True; 2) c; 3) Through the POS network

**Frequently Asked Questions (BIC)**

**Question: What changes occur if the recipient’s BIC needs to be replaced?**

Answer: A replacement BIC has the recipient’s new identification number and shows a new date of issue.

**Question: How often is the BIC issued to a recipient?**

Answer: BICs are issued once, unless reported lost or stolen.

**Question: When should a recipient’s eligibility be verified?**

Answer: Eligibility is determined on a month-to-month basis and is subject to change. It is important that providers verify Medi-Cal recipient eligibility prior to rendering services.

**Question: What information is NOT provided on the BIC and can only be determined by performing an eligibility inquiry?**

Answer: The following information is not provided on a BIC: eligibility, SOC, Other Health Coverage (OHC)/Medicare Coverage, special programs or restricted services.

**Brainteaser**

A provider may ask a recipient for a second ID to help confirm a recipient’s identification.  
 True  False

Answer Key: True

# POS Network

The Point of Service (POS) network allows providers to access information related to these topics:

- Recipient eligibility
- Share of Cost (SOC)
- Scope of benefits/services
- Other Health Coverage (OHC)
- Medicare
- Medi-Cal Managed Care Plans (MCP)
- Medi-Services

## POS Network Access

The POS network is accessed using any one of following methods:

- POS device (BIC card reader)
- Internet (Medi-Cal website)
- Third Party Software (contact CMC Help Desk at 1-800-541-5555.)
- Telephone Automated Eligibility Verification System (AEVS) at 1-800-456-2387

### Brainteaser

To access recipient eligibility, you must have the following information:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### NOTES

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**Answer Key:** 1) ID number; 2) date of birth; 3) date of issue

## Eligibility Verification by POS Device (BIC Card Reader)

### Requirements

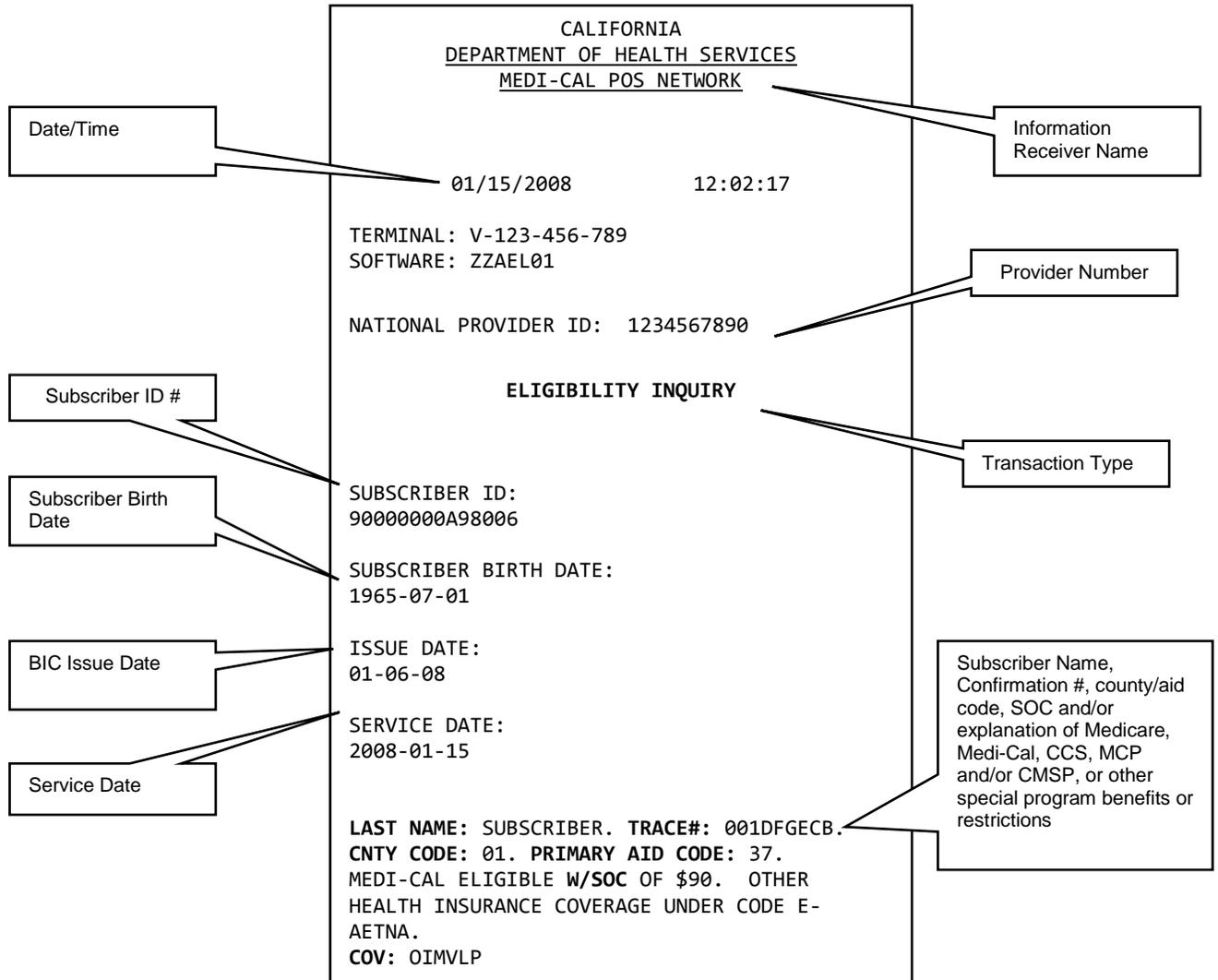
- Medi-Cal POS Network/Internet Agreement form
- Medi-Cal Provider Identification Number (User ID) and a password (PIN)

### Features

- Free of charge to all active providers
- Triggered by swiping the BIC through the card reader or by keying information on the key pad
- Features eight 20-character display lines to scroll through messages
- Equipped with an integrated modem and printer and a full-size QWERTY keyboard
- Ability to print

### POS Device Printout

Remember to make additional copies of the eligibility receipt. Review the complete message stated on the printout and verify if the patient has SOC, OHC or Medicare coverage.



## Eligibility Verification by Internet (Medi-Cal Website)

### Requirements

- Medi-Cal POS Network/Internet Agreement form
- Medi-Cal Provider Identification Number (User ID) and a PIN

### Features

- Free of charge to all active providers
- Ability to print screen display for a recipient's file
- Capable of batch sending (defined as "single or a batch of up to 99 records")
- Located on the Medi-Cal website ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov))



Eligibility transaction performed by provider: ABC987664  
 on Saturday, December 05, 2007 at 6:05:05 PM



Name: <b>SUBSCRIBER, JANET</b>		
Subscriber ID: <b>9876543210</b>		
Service Date: <b>12/05/2007</b>	Subscriber Birth Date: <b>01/01/1930</b>	Issue Date: <b>01/01/2007</b>
Primary Aid Code: <b>10</b>	First Special Aid Code: <b>80</b>	
Second Special Aid Code:		Third Special Aid Code:
Subscriber County: <b>57 - Yolo</b>	HIC Number: <b>123456789Z</b>	
Trace Number (Eligibility Verification Confirmation (EVC) Number): <b>123V12345V</b>		
Eligibility Message: SUBSCRIBER LAST NAME: SUBSCRIBER. EVC # 123V12345V. CNTY CODE: 57. PRMY AID CODE: 10. 1 <sup>ST</sup> SPECIAL AID CODE: 80. MEDI-CAL ELIGIBLE W/ NO SOC/SPEND DOWN. PART A, B MEDICARE COV W/HIC # 123456789Z. BILL MEDICARE COVERED SVCS TO MEDICARE BEFORE MEDI-CAL.		

### Brainteaser

1. What is the Trace Number (EVC – Eligibility Verification Confirmation Number) \_\_\_\_\_ in the example above?
2. What is the aid code in the example above?

Answer Key: 1) 123V12345V; 2) 10

## Eligibility Verification by State-Approved Vendor Software

### Features

- Providers' existing software may be modified by a vendor
- Providers may purchase a vendor-supplied software package

## Automated Eligibility Verification System (AEVS)

### Features

- Free of charge
- Uses a telephone
- Uses alphabetic code list for alphanumeric BICs

### Limitations

Limited to 10 inquiries per call

### NOTES

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# Learning Activities

## Learning Activity: 1

What type of inquiry is represented on the POS printout below? \_\_\_\_\_

```
DR. MARCUS WELBY
CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
MEDI-CAL POS NETWORK

(916) 555-5555

MM/DD/CCYY          HH:MM:SS

TERMINAL: 000001111
SOFTWARE: ZZZZZ01

NATIONAL PROVIDER ID: 1234567890

MEDI SERVICES

SUBSCRIBER ID:
90000000A98006

SUBSCRIBER BIRTH DATE:
CCYY-MM-DD

ISSUE DATE:
YY-MM-DD

SERVICE DATE:
CCYY-MM-DD

PROCEDURE CODE:
99999

SUBSCRIBER LAST NAME: DOE JOHN.
MEDI SVC RESERVATION APPLIED.
# OF MEDI SVCS REMAINING FOR
MONTH OF SVC ENTERED: 0
```

Answer Key: Medi-Service





# Share of Cost (SOC)

## Introduction

### Purpose

The purpose of this module is to define recipient Share of Cost (SOC), to familiarize participants with the process, to discuss the *Share of Cost Case Summary* form and to explain SOC certification.

### Module Objectives

- Define the SOC process (SOC is sometimes referred to as “spend down”)
- Explain how aid codes and/or specific services may relate to SOC
- Identify how Medi-Cal claims will reflect SOC clearance information
- Present the *Share of Cost Case Summary* form

### Resource Information

#### **Medi-Cal Subscription Service (MCSS)**

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at ([www.medi-cal.ca.gov/mcss](http://www.medi-cal.ca.gov/mcss)).

#### **References**

The following reference materials provide Medi-Cal program and eligibility information.

#### **Provider Manual References**

##### Part 1

*County Medical Services Program (CMSP)* (county med)  
*Share of Cost (SOC)* (share)

##### Part 2

*Share of Cost (SOC): 25-1 Long Term Care* (share ltc)  
*Share of Cost (SOC): CMS-1500* (share cms)  
*Share of Cost (SOC): UB-04 for Inpatient Services* (share ip)  
*Share of Cost (SOC): UB-04 for Outpatient Services* (share op)

#### **Acronyms**

A list of current acronyms is located in the *Appendix* section of this workbook.

# Share of Cost Description

Some Medi-Cal recipients must pay, or agree to be obligated to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share of Cost (SOC).

Example: A Medi-Cal recipient's SOC is similar to a private insurance plan's out-of-pocket deductible.

# Share of Cost Set-Up Process

## Recipient Eligibility Verification

Providers access the Medi-Cal eligibility verification system to determine if a recipient must pay, or agree to be obligated to pay, a SOC. The eligibility verification system is accessed through the Point of Service (POS) network by these methods:

- POS device (BIC Card Reader)
- Internet: Medi-Cal website (*www.medi-cal.ca.gov*)
- Telephone Automated Eligibility Verification System (AEVS)
- Third party state-approved vendor software

POS Device Printout	MEDICAL OFFICE T999999
	01-02-15 17:16:36
	PROVIDER NUMBER: 0123456789
	TRANSACTION TYPE: ELIGIBILITY INQUIRY
	RECIPIENT ID: 91234567A
	YEAR & MONTH OF BIRTH: 1966-12
	DATE OF ISSUE: 11-01-14
	DATE OF SERVICE: 01-02-15
	LAST NAME: ROBERTS. MEDI-CAL RECIP HAS A \$00050 SOC. REMAINING SOC \$50.00.

### Brainteaser

1. What is the recipient's SOC for the month of service?
2. What is the recipient's remaining SOC as of date of service?

**Answer Key:** 1) \$50; 2) \$50

## SOC Certification

Recipients are not eligible to receive Med-Cal benefits until their monthly SOC dollar amount has been certified.

SOC certification means that the Medi-Cal eligibility verification system shows the recipient has paid, or has become obligated to pay, for the entire monthly dollar SOC amount.

Once SOC has been certified, an Eligibility Verification Confirmation (EVC)/Trace number is displayed in the message returned by the Medi-Cal eligibility verification system. Return of an EVC number does not guarantee that a recipient qualifies for full-scope Medi-Cal or County Medical Services Program (CMSP) benefits.

### **NOTE**

Providers should carefully read the eligibility message to determine what Medi-Cal service limitations, if any, apply to the recipient.

## Obligation Payments

Obligated payment means the provider allows the recipient to pay for the services at a later date or through an installment plan. Obligated payments may be used to clear SOC.

SOC obligation agreements are between the recipient and the provider and should be in writing, signed by both parties for protection.

#### 4 Share of Cost (SOC)

## Clearance Transactions

Providers should perform a SOC clearance transaction immediately upon receiving payment or accepting obligation from the recipient for the service rendered. Delays in performing the SOC clearance transaction may prevent the recipient from receiving other medically needed services.

To reverse SOC transactions, providers must enter the same information for a clearance, but specify that the entry is a reversal transaction. After the SOC file is updated, providers receive confirmation that the reversal is complete.

### Brain teaser

1. Generally, a recipient's SOC is determined by the county Social Services (or welfare) Department and is based on the amount of income a recipient receives each month in excess of "maintenance need" levels before Medi-Cal begins to pay.  
True  False
2. Claims submitted for services rendered to a recipient whose SOC is not certified through the Medi-Cal eligibility verification system will be denied.  
True  False
3. When a recipient is unable to pay the SOC at the time of service, providers are required to allow the recipient to "obligate" the SOC amount for the future.  
True  False
4. Provider claims may be reimbursed by Medi-Cal, excluding the SOC amount that was obligated but not paid by the recipient, if the spend down has been cleared in the system.  
True  False
5. Once a recipient has been certified as having met the SOC, reversal transactions can no longer be performed.  
True  False

Answer Key: 1) True; 2) True; 3) False; 4) True; 5) True

# Scope of Coverage

## Program-Specific Coverage

### Long Term Care

Providers who receive an eligibility verification message that indicates a recipient has a Long Term Care (LTC) SOC should not clear the SOC online. LTC SOC is cleared solely by the facility in which the recipient resides. Recipients with aid codes 13, 23, 53 and 63 must have their LTC SOC cleared on the *Payment Request for Long Term Care (25-1)* claim form.

<p style="text-align: center;">ABC FACILITY T999999</p> <p style="text-align: center;">12-05-14 20:09:09</p> <p>PROVIDER NUMBER: 0123456789</p> <p>TRANSACTION TYPE: ELIGIBILITY INQUIRY</p> <p>RECIPIENT ID: 97654321A</p> <p>YEAR &amp; MONTH OF BIRTH: 1918-03</p> <p>DATE OF ISSUE: 08-01-13</p> <p>DATE OF SERVICE: 12-05-14</p> <p>LAST NAME: SMITH. EVC# A999999999. CNTY CODE: 33. PRMY AID CODE 13.MEDI-CAL ELIGIBLE W/LTC SOC OF \$1000.00.</p>
---

**Example: POS message indicating recipient has an LTC SOC**

SOC is certified differently for LTC recipients with specific aid codes. To avoid duplicate billing, hospice providers must indicate the SOC on the *UB-04* claim form when billing for hospice room and board (revenue code 658), if the SOC was not already met on a *Payment Request for Long Term Care (25-1)* claim.

### Obstetric Services

When the provider bills on a global basis for obstetric services, arrangements must also be made to collect or obligate the SOC for the initial antepartum visit (HCPCS code Z1032) and for non-global obstetric services (for example, sonogram or amniocentesis). When the intent to bill globally is prevented because the patient moves or leaves care, providers bill on a fee-for-service basis and collect SOC for each month of service.

### Comprehensive Perinatal Services

Recipients who choose to participate in the Comprehensive Perinatal Services Program (CPSP) are required to pay or obligate their SOC each month even if the obstetrical services are billed globally.

## 6 Share of Cost (SOC)

### Brain teaser

1. When will a provider collect or obligate the SOC for each month in which obstetric services were provided? \_\_\_\_\_

## Multiple Program Coverage

### Multiple Plan Identification Factors (Aid Codes)

Some recipients may qualify for limited-scope Medi-Cal eligibility assistance or for programs other than Medi-Cal at the same time they qualify for full-scope Medi-Cal services with a SOC. Aid codes displayed by the eligibility verification system identify additional programs or services for which Medi-Cal recipients are eligible. In such instances, the recipient may be required to pay a SOC for one set of services, but not for another.

Once the SOC is certified for the month, the recipient is eligible for full-scope Medi-Cal benefits.

#### NOTE

The full-scope aid code will not be displayed until the SOC has been certified.

```
LAST NAME: SMITH/ EVC# A999999999.  
CNTY CODE: 33. 1ST SPECIAL AID  
CODE: 48. MEDI-CAL ELIGIBLE FOR  
PREGNANCY/POSTPARTUM RELATED  
MEDICAL SVCS W/NO SOC. FOR ALL  
OTHER MEDI-CAL SVCS, RECIP HAS SOC  
OF $00500. REMAINING SOC $500.00.
```

**Example: Partial POS message for recipient with multiple eligibility**

### County Medical Services

SOC is calculated independently for CMSP and Medi-Cal; however, the same recipient income is included in both calculations.

Providers may apply the same services used to clear a Medi-Cal SOC obligation to clear a CMSP SOC obligation. However, two separate transactions are required.

### Medicare/Medi-Cal Crossover Claims

Some recipients who are entitled to Medicare also have Medi-Cal with a SOC. In these cases, the patient's liability is limited to the amount of the Medicare deductible and co-insurance.

The collection of Medi-Cal SOC after the Medicare payment will help prevent collecting amounts greater than the Medicare deductible and co-insurance.

### Brain teaser

2. The same medical expenses may be used to clear SOC for both CMSP and Medi-Cal. True  False
3. Clearing SOC for one program does not automatically clear SOC for the other program. True  False
4. When the recipient is eligible for both Medicare and Medi-Cal, providers should collect the Medi-Cal SOC at the time of service. True  False

**Answer Key:** 1) Per-visit basis; 2) True; 3) True; 4) False

## Multiple Case Numbers

Eligibility messages may include multiple case numbers. When there are two or more case numbers in an eligibility verification message, they are listed in numerical order.

### Share of Cost Case Summary Form

Recipients who have multiple case numbers will receive the *Share of Cost Case Summary* form on a monthly basis.

- Providers must refer to the *Share of Cost Case Summary* form to determine which case numbers correspond to which recipient.
- Recipients who are in more than one SOC case will receive a *Share of Cost Case Summary* form that lists all of the cases for which the recipient may clear SOC.

According to the Sneede v. Kizer lawsuit, a recipient’s eligibility and SOC must be determined using his/her own property. Children and spouses within the same family may have varying SOC’s and, therefore, multiple case numbers are listed on the *Share of Cost Case Summary* form. Refer to the next page for the *Share of Cost Case Summary* form example.

### Brainteaser

1. The first case number listed on an eligibility response will correspond with the recipient for whom eligibility is being verified.  
True       False
2. In the *SOC Case Summary* form example found on the following page, can Sally apply her \$100 Medical expenses to her child’s SOC?  
Yes       No
3. In the family SOC example on the following page, can the mother apply a portion of the \$100 to her own SOC and the balance to her child’s SOC?  
Yes       No

### NOTES

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Answer Key: 1) False; 2) Yes; 3) Yes

8 Share of Cost (SOC)

The reverse side of the *Share of Cost Case Summary* form contains additional information regarding family SOC.

**SHARE OF COST CASE SUMMARY**  
**CARRY THIS WITH YOU TO YOUR MEDICAL APPOINTMENTS**  
**RESUMEN DEL CASO DE LA PARTE DEL COSTO**  
**LLEVE ESTO CONSIGO A SUS CITAS MEDICAS**

RECIPIENT NAME  
 1234 MAIN AVENUE  
 ANYTOWN, CA 99999-9999

Good for the month listed here

**THE SHARE OF COST FAMILY GROUPINGS for the month of \_\_\_\_\_ are:**

This information is being sent to you because your medical expenses may be used to meet your share of cost, if any, or the share of cost of other family members. This is because you appear in more than one family group. Other family members may only use their medical expenses to meet their own share of cost for the month.

Se le envia esta informacion puesto que es posible que sus gastos medicos puedan utilizarse para cumplir con su parte del costo, si tiene alguna, o la parte del costo de otros miembros de la familia. Esto es debido a que usted aparece en mas de un grupo familiar Otros miembros de la familia solo pueden utilizar sus gastos medicos para cumplir con su propia parte del costo para el mes. Las agrupaciones familiares para la parte del cost son.

<u>BENEFICIARY NAME</u>	<u>MEDS ID</u>	<u>AID CODE</u>	<u>BIRTHDATE</u>	<u>SOC AMT</u>
<i>NOMBRE DEL BENEFICIARIO</i>	<i>NO. DE IDENT. DEL MEDS</i>	<i>CLAVE de ASISTENCIA</i>	<i>DIA DE NACIMIENTO</i>	<i>CANTIDAD DEL SOC</i>
<b>CASE NUMBER/Numero de caso: 07-9234567-0</b>				<b>\$ 1,200.</b>
Tate-Smith, Sally	93541073A77103	37	08/03/79	
Smith, John	92337742A67363	IE	07/03/71	
<b>CASE NUMBER/Numero de caso: 07-9234567-A</b>				<b>\$ 1,200.</b>
Smith, Freddie	95546123A67031	37	01/09/05	
Tate-Smith, Sally	93541073A77103	RR	08/03/79	
Smith, John	92337742A67363	RR	07/03/71	
<b>CASE NUMBER/Numero de caso: 07-9234567-B</b>				<b>\$ 100.</b>
Tate, Susie	93662178A77005	37	03/12/01	
Tate-Smith, Sally	93541073A77103	RR	08/03/79	

IE  
(Ineligible)

RR  
(Responsible Relative)

SOC  
(Share of Cost)

**Example:**

The Smith family consists of a stepfather (husband John Smith), a mother (wife Sally Tate-Smith), a son (Freddie Smith) from the husband and wife, and the mother's separate child (Susie Tate) from a previous marriage. The husband is listed on the first case as "IE" Ineligible recipient with the wife having an SOC of \$1200.00. The mother and father are listed as "RR" (Responsible Relative) with their child Freddie Smith in the second case with a \$1200.00 SOC. The mother is also on her daughter's case listed as an RR.

# Billing Information

## Unpaid Medical Expenses

### General Policy

According to Hunt v. Kizer, the Department of Health Care Services (DHCS) no longer imposes time limits on unpaid medical expenses that Medi-Cal recipients may use to meet their SOC.

### NOTE

Although the County Medical Services Program (CMSP) was not a party to this lawsuit, the CMSP also has adopted the court-ordered SOC changes to simplify the administration of unpaid expenses.

### Long Term Care Policy

According to Johnson v. Rank, current unpaid medical bills are still applied against current SOC at the nursing home for LTC patients. Therefore, nursing homes should continue their current procedure of deducting from SOC the bill and receipts submitted within the last two months of the current month.

## Claim Form Completion

This section of the workbook module explains how to complete claims for services rendered to recipients who paid a Share of Cost (SOC). The following forms will be discussed:

- *CMS-1500* claim form
- *Payment Request for Long Term Care (25-1)* claim form
- *UB-04* claim form

Refer to the correct section to locate specific information regarding form completion.

### NOTES

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## CMS-1500 Claim Form

The following information provides guidelines for entering SOC quantities on the CMS-1500 claim form.

### Form Fields

SOC amounts are entered in these fields:

- Box 10d (Claim Codes)
- Box 29 (Amount Paid)

### Instructions

Enter full dollar and cents amount, even if the amount is even. Do not enter decimal points (.) or dollar signs (\$).

In the example below, \$4.00 is entered as 400.

d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC) <b>400</b>		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL: _____		15. OTHER DATE QUAL: _____ MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____				22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. L _____		B. L _____		C. L _____	
E. L _____		F. L _____		G. L _____	
I. L _____		J. L _____		K. L _____	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG	
		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER	
1 01 06 15		11		Procedure code/modifier	
				1500 1	
				NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.	
		<input type="checkbox"/> <input type="checkbox"/>			
				27. ACCEPT ASSIGNMENT? (For print claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
				28. TOTAL CHARGE \$ 1500	
				29. AMOUNT PAID \$ 400	
				30. Rsvd for NUCC Use	

**Example: SOC amount in Claim Codes field (Box 10d) and Amount Paid field (Box 29)**





# Learning Activities

## Learning Activity 1: Multiple Services on Different Dates

### Case Scenario

A recipient with an abscess on her finger goes to the doctor's office. The doctor examines the finger and sends the patient home with some initial treatment instructions. The abscess does not clear up and she returns to the doctor, who makes an appointment to drain the abscess the following day. The recipient has a \$40.00 SOC.

Dates	Service	Amount	SOC Cleared
06/01/14	Office Visit	\$20.00	\$20.00
06/14/14	Office Visit	\$15.00	\$15.00
06/15/14	Drainage	\$20.00	\$ 5.00
<b>Total:</b>		<b>\$55.00</b>	<b>\$40.00</b>

### Brainteaser

What information will be submitted on this claim form? How will the collected SOC be entered on the claim form?

d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL		15. OTHER DATE QUAL MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.				22. RESUBMISSION CODE ORIGINAL REF. NO.	
A. _____		B. _____		23. PRIOR AUTHORIZATION NUMBER	
E. _____		F. _____			
I. _____		G. _____			
J. _____		H. _____			
K. _____		L. _____			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
				E. DIAGNOSIS POINTER	
				F. \$ CHARGES	
				G. DAYS OR UNITS	
				H. ICD-9-CM Plan	
				I. ID. QUAL	
				J. RENDERING PROVIDER ID. #	
				NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.	
				27. ACCEPT ASSIGNMENT? (For Govt. Claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
				28. TOTAL CHARGE \$	
				29. AMOUNT PAID \$	
				30. Rsvd for NUCC Use	

CMS-1500 claim form

**Answer Key:** Refer to the *Share of Cost (SOC): CMS-1500* section (share cms), in the appropriate Part 2 provider manual.

## Learning Activity 2: Multiple Services on Same Date

### Case Scenario

A recipient requires speech therapy services and he receives two speech therapy services on the same day. Recipient has an \$85.00 SOC.

Dates	Service	Amount	SOC Cleared
06/02/14	Speech Evaluation (X4301)	\$75.00	\$75.00
06/02/14	Speech Therapy (X4303)	\$50.00	\$10.00
Total:		\$125.00	\$85.00

### Brainteaser

What information will be submitted on this claim form? How will the collected SOC be entered on the claim form?

d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL: _____		15. OTHER DATE MM DD YY QUAL: _____		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____				22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____	
A. _____ B. _____ C. _____ D. _____		E. _____ F. _____ G. _____ H. _____		23. PRIOR AUTHORIZATION NUMBER _____	
I. _____ J. _____		K. _____ L. _____			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	
				E. DIAGNOSIS POINTER	
				F. \$ CHARGES	
				G. DAYS OR UNITS	
				H. EPSON Plans Pen	
				I. ID. QUAL	
				J. RENDERING PROVIDER ID. #	
				NPI	
25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.	
				27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
				28. TOTAL CHARGE \$	
				29. AMOUNT PAID \$	
				30. Rsvd for NUCC Use	

**CMS-1500 claim form**

**Answer Key:** Refer to the *Share of Cost (SOC): CMS-1500* section (share cms) in the appropriate Part 2 provider manual.

# Learning Activity 3: Inpatient Claim with SOC

## Case Scenario

A recipient has a \$100.00 SOC. She paid \$50.00 to provider “A”, who performed a SOC clearance transaction for \$50.00. The remaining \$50.00 is paid or obligated to the hospital staff (provider “B”), which performs a second SOC clearance transaction. The recipient’s SOC is now fully certified. The total cost of services rendered for the inpatient claim is \$3,430.00.

## Brainteaser

What information will be submitted on this claim form? How will the collected SOC be entered on the claim form?

The image shows a UB-04 claim form with several sections and fields. Key areas include:

- Header Section:** Fields for 39 CODE, 40 VALUE CODES AMOUNT, 41 CODE, and 42 VALUE CODES AMOUNT.
- Table Section:** A table with columns for 42 REV. CD, 43 DESCRIPTION, 44 HCPCS / RATE / HIPPS CODE, 45 SERV. DATE, 46 SERV. UNITS, 47 TOTAL CHARGES, 48 NON-COVERED CHARGES, and 49.
- Summary Section:** Fields for 50 PAYER NAME, 51 HEALTH PLAN ID, 52 REL INFO, 53 ADJ BEN, 54 PRIOR PAYMENTS, 55 EST. AMOUNT DUE, 56 NPI, and 57 OTHER PRV ID.
- Insurance Section:** Fields for 58 INSURED'S NAME, 59 PEEL, 60 INSURED'S UNIQUE ID, 61 GROUP NAME, and 62 INSURANCE GROUP NO.
- Authorization Section:** Fields for 63 TREATMENT AUTHORIZATION CODES, 64 DOCUMENT CONTROL NUMBER, and 65 EMPLOYER NAME.
- Procedure Section:** Fields for 67 (A-H), 68 DX, 69 ADMIT DX, 70 PATIENT REASON DX, 71 PPS CODE, 72 ECI, 73, 74 PRINCIPAL PROCEDURE CODE, 75 OTHER PROCEDURE CODE, 76 ATTENDING NPI, 77 OPERATING NPI, 78 OTHER NPI, and 79 OTHER NPI.
- Remarks Section:** Field for 80 REMARKS with sub-fields a, b, c, d.
- Footer:** Includes NUBC logo and the text "THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF."

**UB-04 claim form**

## NOTE

For record keeping purposes only and to help reconcile payment on the *Remittance Advice Details (RAD)* form, providers may show in the *Remarks* field (Box 80) the SOC amount that the recipient paid or is obligated to pay.

**Answer Key:** Refer to the *Share of Cost (SOC): UB-04 Inpatient Services* section (share ip) in the appropriate Part 2 provider manual.



# Treatment Authorization Request (TAR)

## Introduction

### Purpose

The purpose of this module is to provide an overview of the *Treatment Authorization Request* (TAR) process and to review completion requirements for the *Treatment Authorization Request* (50-1) form, as well as the *Request for Extension of Stay in Hospital* (18-1) form.

### Module Objectives

- Explain how to determine when authorization is required
- Discuss the medical justification that is required for a TAR approval
- Review documentation on a TAR
- Discuss attachments
- Identify the critical data areas required to complete a *Treatment Authorization Request* (50-1) form and a *Request for Extension of Stay in Hospital* (18-1) form
- Review the *Adjudication Response* (AR)

### Resource Information

#### **Medi-Cal Subscription Service (MCSS)**

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at ([www.medi-cal.ca.gov/mcss](http://www.medi-cal.ca.gov/mcss)).

## 2 Treatment Authorization Request (TAR)

### References

The following reference materials provide Medi-Cal program and eligibility information.

#### Provider Manual References

##### Part 1

*TAR Overview* (tar)

##### Part 2

*TAR and Non-Benefit List* (tar and non)

*TAR Completion* (tar comp)

*TAR Field Office Addresses* (tar field)

*TAR Request for Extension of Stay in Hospital (Form 18-1)* (tar req ext)

#### Other References

*The Manual of Criteria for Medi-Cal Authorization*

*California Code of Regulations Title 22*

### Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

## TAR Description

Authorization requirements are applied to specific procedures and services according to state and federal law. Certain medical procedures and services require authorization from the Department of Health Care Services (DHCS) before reimbursement is approved.

To acquire treatment authorization, mail the *Treatment Authorization Request* (50-1) form or the *Request for Extension of Stay in Hospital* (18-1) form to:

Xerox TAR Processing Center  
820 Stillwater Road  
West Sacramento, CA 95605-1630

#### NOTE

The *50-3 Treatment Authorization Request* for vision care services will not be discussed in this training session.

Refer to the "Resource Information" section of this module for provider manual references that apply to TAR procedures discussed in this workbook.

# Documentation Requirements

## Medical Justification

It is the provider's responsibility to provide all necessary documentation and justification for TAR processing. Information regarding proper medical justification is found in the *TAR Overview* section (tar) in the Part 1 provider manual.

## Medical Necessity

Providers must justify that the services they are requesting are medically necessary. The Medi-Cal program definition of medical necessity limits the provision of health care services to the following scenarios:

- Take actions that are reasonable and necessary to protect life
- Prevent significant illness
- Aid individuals with significant disability
- Alleviate severe pain

# TAR 50-1 Form

## Form Completion Process

Physicians, podiatrists, pharmacies, medical supply dealers, outpatient clinics, Community-Based Adult Services (CBAS) and laboratories use the TAR 50-1 form to request approval from a Medi-Cal TAR field office consultant for certain procedures/services.

Refer to the *TAR Completion* section (tar comp) in the appropriate Part 2 provider manual. The following pages include excerpts from the *TAR Completion* section (tar comp).

If you are unsure if a procedure requires authorization, contact the DHCS Fiscal Intermediary (FI) Telephone Service Center (TSC) at 1-800-541-5555.

### NOTES

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4 Treatment Authorization Request (TAR)

**Treatment Authorization Request (50-1) Form**

STATE USE ONLY **1**

**5** CONFIDENTIAL PATIENT INFORMATION **40** F.I. USE ONLY

FOR F.I. USE ONLY

**1A**

CCN

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

TYPEWRITER ALIGNMENT **43**

Elite Pica

**FOR PROVIDER USE (PLEASE TYPE)**

VERBAL CONTROL NO. **1B**

TYPE OF SERVICE REQUESTED **2** DRUG OTHER

REQUEST IS RETROACTIVE? YES NO

IS PATIENT MEDICARE ELIGIBLE? YES NO **2A**

PROVIDER PHONE NO. **2A**

PROVIDER NAME AND ADDRESS **2B**

3. PROVIDER NUMBER **3**

**PLEASE TYPE YOUR NAME AND ADDRESS HERE**

**NAME AND ADDRESS OF PATIENT**

PATIENT NAME (LAST, FIRST, M.I.) **4**

MEDI-CAL IDENTIFICATION NO. **5**

SEX AGE DATE OF BIRTH **7** **8**

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER ( )

PATIENT STATUS: HOME BOARD & CARE SNF / ICF ACUTE HOSPITAL **8A**

DIAGNOSIS DESCRIPTION: **8B**

MEDICAL JUSTIFICATION: **8C**

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:**

**32A**

**33**

**FOR STATE USE**

**33 PROVIDER, YOUR REQUEST IS:**

1  APPROVED AS REQUESTED  DENIED  DEFERRED

2  APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED)  JACKSON VS RANK PARAGRAPH CODE

BY I.D. # DATE REVIEW COMMENTS INDICATOR

34 35 44

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)

**9**

**36** 1 2 3 4 5 6 **36**

LINE NO.	AUTHORIZED Y/M	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1	9	10	<b>10</b> <b>10A</b>	<b>10B</b>	11 <b>11</b>	12 <b>12</b>	\$ <b>12A</b>
2	13	14			15	16	\$
3	17 <b>13</b>	18			19	20	\$
4	21	22			23	24	\$
5	25	26			27	28	\$
6	29	30			31	32 <b>32</b>	\$

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

**39A**

SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED FROM DATE **37** DATE **38**

**TAR CONTROL NUMBER**

OFFICE SEQUENCE NUMBER PI **39**

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

PROVIDER COPY 50-1 03/07

**Brainteaser**

List two requirements for a retroactive TAR.

1) \_\_\_\_\_, 2) \_\_\_\_\_

Answer Key: 1) retroactive request; 2) service date for retroactive request

**TAR 50-1 Form Fields**

Locator #	Form Field	Instructions
1	STATE USE ONLY	Leave this area blank.
1A	CLAIM CONTROL NUMBER	For FI Use ONLY. Leave blank.
1B	VERBAL CONTROL NUMBER	Providers may enter a fax number in this field to receive an AR for the submitted TAR by fax, instead of standard mail. If a fax number is entered, an AR will not be mailed to the provider for the related TAR that was submitted.
2	TYPE OF SERVICE REQUESTED/ RETROACTIVE REQUEST/MEDICARE ELIGIBILITY STATUS	Enter an "X" in the appropriate boxes to show DRUG or OTHER, RETROACTIVE request, "Yes" or "No" and MEDICARE eligibility status "Yes" or "No".
2A	PROVIDER PHONE NUMBER	Enter the telephone number and area code of requesting provider.
2B	PROVIDER NAME & ADDRESS	Enter provider name and address, including nine-digit ZIP code.
3	PROVIDER NUMBER	Enter the National Provider Identification (NPI) number for the Medi-Cal rendering provider in this area. When requesting authorization for an elective hospital admission, the hospital NPI number must be entered in this box. (Enter the hospital name in the <i>Medical Justification</i> field. If this information is not present, the TAR will be returned to the provider unprocessed.)
4	PATIENT NAME, ADDRESS, AND TELEPHONE NUMBER	Enter recipient information in this area.
5	MEDI-CAL IDENTIFICATION NUMBER	When entering only the recipient's identification number from the Benefits Identification Card (BIC), begin in the farthest left position of the field. For Family PACT requests, enter the client's Health Access Programs (HAP) card ID number, instead of the BIC number. The county code and aid code must be entered just above the recipient Medi-Cal Identification Number field. Do not enter any characters (dashes, hyphens or special characters) in remaining blank positions of the Medi-Cal Identification Number field or in the Check Digit box.
6	PENDING	Leave blank.
7	SEX AND AGE	Use the capital "M" for male or "F" for female. Enter the age of the recipient in the Age box.
8	DATE OF BIRTH	Enter the recipient's date of birth in a six-digit format (MMDDYY). If the recipient's full date of birth is not available, enter the year of the recipient's birth preceded by "0101."
8A	PATIENT STATUS	Enter the recipient's residential status. If the recipient is an inpatient of a Nursing Facility (NF) Level A or B, enter the name of the facility in the <i>Medical Justification</i> field.

6 Treatment Authorization Request (TAR)

Locator #	Form Field	Instructions
8B	DIAGNOSIS DESCRIPTION AND ICD-9-CM DIAGNOSIS CODE	Always enter the English description of the diagnosis and its corresponding code from the ICD-10-CM codebook.
8C	MEDICAL JUSTIFICATION	Provide sufficient medical justification for the consultant to determine whether the service is medically justified. If necessary, attach additional information. If the recipient is a patient in an NF-A or NF-B, enter the name of the facility in the <i>Medical Justification</i> field.  <u>Family PACT:</u> Enter "Family PACT Client" on the first line of this field. Enter a secondary ICD-10-CM diagnosis code when the TAR is for complications of a secondary related reproductive health condition. If applicable, attach a copy of the <i>Family PACT Referral</i> form from the enrolled Family PACT provider.
9	AUTHORIZED YES/NO	Leave blank. Consultant will indicate on the AR if the service line item is authorized.
10	APPROVED UNITS	Leave blank. Consultant will indicate on the AR the number of times that the procedure, item or days have been authorized.
10A	SPECIFIC SERVICES REQUESTED	Indicate the name of the procedure, item or service.
10B	UNITS OF SERVICE	Leave blank.
11	NDC/UPC OR PROCEDURE CODE	Enter the anticipated code (five-character HCPCS, five-digit CPT-4 [followed by a two-digit modifier when necessary] or an 11-digit NDC code). When requesting hospital days, the stay must be requested on the first line of the TAR with the provider entering "Day" or "Days."
12	QUANTITY	Enter the number of times a procedure or service is requested, or the number of hospital days requested. Drugs requested should have the amount to be dispensed on each fill. Enter the total number of tablets, capsules, volume of liquid (ml) or quantity of ointments/creams (grams).
12A	CHARGES	Indicate the usual and customary dollar amount for the service(s) requested. If an item is a taxable medical supply, include the applicable state and county sales tax. For additional information, refer to the <i>Taxable and Non-Taxable Items</i> section (tax) in the appropriate Part 2 provider manual.
13 – 32	ADDITIONAL LINES 2 – 6	Additional TAR lines. Up to six drugs or supplies may be requested on one TAR.
32A	PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS	If applicable, enter the name and address of the recipient's authorized representative, representative payee, conservator, legal representative or other representative handling the recipient's medical and/or personal affairs.

Locator #	Form Field	Instructions
33 – 36	FOR STATE USE	<p>Leave blank. Consultant's determination and comments will be returned on the AR.</p> <p><b>NOTE</b> Only submit the claim if the AR decision is Approved as Requested or Approved as Modified. <u>Denied and deferred</u> decisions indicate that the provider's request has not been approved.</p>
37 – 38	AUTHORIZATION IS VALID FOR SERVICES PROVIDED FROM DATE/TO DATE	<p>Leave blank. The AR will indicate valid dates of authorization for the TAR.</p>
39	TAR CONTROL NUMBER	<p>Leave blank. The AR will indicate the 11-digit number that must be entered on the claim form when this service is billed. This number will show that authorization has been obtained. <u>Do not attach a copy of the AR to the claim form.</u> The TAR Control Number on a TAR 50-1 may serve as the initial admit TAR # on an elective admission for the hospital.</p>
39A	SIGNATURE OF PHYSICIAN OR PROVIDER	<p>Form must be signed by the physician, pharmacist or authorized representative.</p>
40 – 43	F.I. USE ONLY	<p>Leave blank.</p>

# Request for Extension of Stay in Hospital (18-1) Form

## Form Completion Process

Information about form 18-1 is located in the *TAR Request for Extension of Stay in Hospital (Form 18-1)* section (tar req ext) in the *Part 2 Inpatient Services* provider manual. The following pages include excerpts from the TAR 18-1 form section.

Hospitals must request authorization for emergency admissions on a *Request for Extension of Stay in Hospital (18-1)* form for the number of days of the stay. This TAR is only authorized for inpatient hospital use and is not for physicians or outpatient hospitals billing specific TAR-required procedures. Physicians must submit a TAR (50-1) for surgical procedures that require authorization.

### **Elective Acute Admissions**

All elective acute inpatient admissions, except for certain excluded admissions, are reviewed for medical necessity and authorized, as appropriate, using a TAR (50-1).

### **NOTES**

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### Request for Extension of Stay in Hospital (TAR 18-1) Form

#### REQUEST FOR EXTENSION OF STAY IN HOSPITAL

STATE OF CALIFORNIA  
DEPARTMENT OF  
HEALTH CARE  
SERVICES

STATE  
USE  
ONLY

1. CLAIMS CONTROL NUMBER F.I. USE ONLY

1

2

3

4

5

CONFIDENTIAL PATIENT INFORMATION

PLEASE TYPE ALL INFORMATION  
TYPEWRITER ALIGNMENT

**HOSPITAL USE**

ELITE PICA

ELITE PICA

ELITE PICA

<b>ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER)</b>	<b>ADMIT DATE</b>	<b>ADMIT EXP.</b>	<b>EMER. ADMIT.</b>	<b>PATIENT MEDI-CAL ID NO.</b>	<b>SEX</b>	<b>DATE OF BIRTH</b>	<b>AGE</b>
6	7 MM/DD/YY	8 MM/DD/YY	9	11	12	13 MM/DD/YY	14A
<b>PROVIDER NUMBER</b>	<b>PROVIDER PHONE NO.</b>	<b>VERBAL CONTROL</b>		<b>PATIENT NAME</b>		<b>MEDICARE STATUS</b>	<b>OTHER COV.</b>
10	10A	10B		14B		15	16
<b>PROVIDER NAME</b>				<b>DISCHARGE DATE</b>		<b>ADMITTING PHYSICIAN</b>	
10C				17		18	
<b>PROVIDER STREET/MAILING ADDRESS</b>				<b>ADMITTING DIAGNOSIS DESCRIPTION</b>		21	
<b>PROVIDER CITY, STATE AND ZIP CODE</b>				21A			

FOR PHYSICIAN- PLEASE PROVIDE SUFFICIENT ESSENTIAL DETAIL TO PERMIT A REASONABLE EVALUATION OF THE LENGTH AND LEVEL OF CARE REQUESTED.

<b>CURRENT DIAGNOSIS</b>	<b>PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS</b>
22	22A
DESCRIBE CURRENT CONDITION REQUIRING EXTENSION, INCLUDE PERTINENT LAB AND X-RAY REPORTS WITH DATES.	

WHAT PLANNED PROCEDURES WILL REQUIRE THIS EXTENSION, INCLUDE DATES WHEN POSSIBLE.

<b>HOSPITAL:</b> TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.	<b>TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN</b>	<b>SIGNATURE OF RESPONSIBLE PHYSICIAN</b>	<b>DATE</b>
DATE		X	22B

<b>MEDI-CAL CONSULTANT- VALIDATING INFORMATION AND EXPLANATION</b>	<b>FOR STATE USE ONLY</b>
22C	23 <input checked="" type="checkbox"/> DENIED 24 <input checked="" type="checkbox"/> DEFERRED 25 <input type="checkbox"/> APPROVED AS REQUESTED 26 <input type="checkbox"/> APPROVED AS MODIFIED 27 <input type="checkbox"/> DAYS OF THIS HOSPITALIZATION ARE DENIED (SEE COMMENTS) 28 <input type="checkbox"/> JACOBS VS RANK PARAGRAPH CODE 29 <input type="checkbox"/> RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 5180 (S)
CHART REVIEWS REVIEW COMMENTS INDICATOR	24 FROM AS REQUESTED MM/DD/YY 26 THRU MM/DD/YY 27 ACUTE ADULT SUB ADOLESCENT 28 DATES OF DAYS DENIED 29 1 2 3 4 5 6

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

18-1 3/07

**TAR 18-1 Form Fields**

Locator #	Form Field	Instructions
1	CLAIMS CONTROL NUMBER	Leave blank. For FI use only.
2 – 5	F.I. USE ONLY	Leave blank.
6	ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER)	Enter the 11-digit TAR Control Number from the original admitting TAR when additional hospital days are requested. For emergency admits, refer to Item 9. The <i>Emergency Admit</i> field (Box 9) must be left blank when the <i>Admit TAR Number</i> field is completed.
7	ADMIT DATE	Enter the date of admission using the six-digit format (MMDDYY).
8	AUTHORIZATION EXPIRES	If there is a previous TAR for this admission, coverage by another health care provider or State program, enter the expiration date of the previous TAR last date covered by the other insurance or State program. If no previous TAR, leave blank.
9	EMERGENCY ADMIT	Enter an "X" if a patient was admitted to the hospital under these conditions: without a previously approved TAR, an emergency, or a direct admission and this is the initial authorization. Leave blank on subsequent extension TARs for recipient.
10	PROVIDER NUMBER	Enter the Provider Number/NPI that uniquely identifies the facility or program.
10A	PROVIDER PHONE NUMBER	Enter the provider's telephone number including area code.
10B	VERBAL CONTROL	Providers may enter a fax number in this field to receive an AR for the submitted TAR by fax instead of standard mail. If a fax number is entered in this field, an AR will not be mailed to the provider for the related TAR that was submitted.
10C	PROVIDER NAME AND ADDRESS	Enter the name of the hospital, street address, city, state and nine-digit ZIP code.
11	PATIENT MEDI-CAL ID NUMBER AND CHECK DIGIT	Enter the recipient's 14-digit Medi-Cal ID number from the BIC. Enter the county code and aid code below Box 11.
12	PEND	Leave blank.
13	SEX	Enter the patient's gender. <ul style="list-style-type: none"> <li>• "F" for female</li> <li>• "M" for male</li> </ul>
14	DATE OF BIRTH	Enter the recipient's date of birth in six-digit format (MMDDYY).
14A	AGE	Enter the recipient's age.
14B	PATIENT NAME	Enter the recipient's last name, first name and middle initial.

Locator #	Form Field	Instructions
15	MEDICARE STATUS	<p>If Medicare is not billed, enter the appropriate Medicare status code number. Refer to the <i>UB-04 Completion: Inpatient Services</i> section in the manual for a listing of Medicare status codes.</p> <p><b>NOTE</b> If a patient's EVC label shows a "2" indicating Medicare coverage, and Medicare is not billed, the Medicare status code must be other than "0" regardless of the age of the patient.</p>
16	OTHER COVERAGE	Enter an "X" if the recipient has other insurance or Other Health Coverage (OHC).
17	NUMBER OF DAYS	<p>Enter the number of days requested on the TAR.</p> <p>DRG Admit TAR: Enter "1".</p> <p>Daily TAR: Enter the number of days requested.</p>
18	TYPE OF DAYS	<p>Enter the code indicating type of days requested.</p> <p>0 Acute 2 Administrative 3 Subacute administrative ventilator dependent 4 Subacute administrative non-ventilator dependent</p>
19	RETROACTIVE	Enter a capital "X" if Medi-Cal eligibility was approved retroactively.
20	DISCHARGE DATE	<p>Enter the date the patient was discharged from the facility.</p> <p>DRG: Enter the date following the date of admission.</p>
21	ADMITTING ICD-9-CM	Enter the numeric code for the admitting diagnosis from the ICD-10-CM codebook.

12 Treatment Authorization Request (TAR)

Locator #	Form Field	Instructions
21A	ADMITTING DIAGNOSIS DESCRIPTION AND ICD-9-CM DIAGNOSIS CODE	Always enter the English description of the diagnosis from the ICD-10-CM codebook.
22	CURRENT DIAGNOSIS	Enter the current ICD-10-CM diagnosis code and medical justification. Provide sufficient medical justification for the Medi-Cal consultant to determine whether the service is medically necessary. Attach additional information, if necessary.
22A	PATIENT'S AUTHORIZED REPRESENTATIVE	Enter the name and address (if known) of the patient's authorized representative, representative payee, conservator, legal representative or other representative handling the recipient's medical and personal affairs.
22B	SIGNATURE OF RESPONSIBLE PHYSICIAN	Must be signed and dated by the admitting physician or other licensed personnel with admitting privileges. The provider assumes full legal responsibility to DHCS for the information provided by the representative. Original signatures are required.
23 – 42	FOR STATE USE ONLY	Leave blank.
42A	SUB. ADMIN. VENT/SUB ADMIN N-VENT	The Medi-Cal field office consultant will mark the appropriate box. If billing for subacute care, enter the accommodation code on the claim that corresponds to the checked box on the TAR.
42B	MEDI-CAL CONSULTANT	Leave blank.
43 – 44	ID. NO./DATE	Medi-Cal consultant completes.
45	TAR CONTROL NUMBER	This number is imprinted on the form and will have a prefix and suffix added to it by the Medi-Cal consultant.

# Authorization Findings

## Adjudication Response

Providers no longer receive TAR adjudication results on a paper TAR. Instead, providers receive an *Adjudication Response* (AR) via the Internet with the following information, as appropriate:

- The status of the requested services
- Information required to submit a claim for TAR-approved services
- The reason(s) for the decision(s)
- TAR decisions resulting from an approved or modified appeal
- The TAR consultant's request for additional information, if necessary
- The Pricing Indicator (PI) needs to be added to the TAR Control Number (TCN) when submitting a claim

Providers should keep a copy of the AR for resubmitting a deferred paper TAR, or when requesting an update or correction to a previously approved or modified paper TAR.

State of California - Health and Human Services Agency Department of Health Care Services		<b>CONFIDENTIAL</b>								
		<b>ADJUDICATION RESPONSE</b>								
Provider Number: 0099219517 NPI TST CLINIC 3.1 3215 PROSPECT PARK DR RNCHO CORDOVA, CA 95670-6017		DCN (Internal Use Only): 123456789101 Date of Action: 12/27/2007 04:47 PM Regarding: Jane Doe TAR Control Number: 9876543210 Patient Record #: 12345								
This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:										
Svc #	Svc Code	Modifier(s)	From Date of Service	Thru Date of Service	Units	Quantity	% Var	Price	Status	PI
1	123ABC		01-01-2008	01-31-2008	12,345	1,000,000.123		9.99	Approved	1
Svc Desc :		Service Description 1								
2	ABC123		01-01-2008	01-31-2008	12,345	1,000,000.123			Modified	0
Svc Desc :		Service Description 2								
Reason(s):		GEN: Modified, refer to comments								
Comment(s):		Comments from Field Office Consultant 2								
3	ABC123		01-01-2008	01-31-2008	12,345	1,000,000.123		9,999,999.99	Denied	3
Svc Desc :		Service Description 3								
Reason(s):		GEN: Denied, refer to comments								
Comment(s):		Comments from Field Office Consultant 3								
4	ABC123		01-01-2008	01-31-2008	12,345	1,000,000.123		9,999,999.99	Deferred	5
Svc Desc :		Service Description 4								
Reason(s):		GEN: Deferred, refer to comments								
Comment(s):		Comments from Field Office Consultant 4								
Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service.										
If you have received this document in error, please call the Telephone Service Center, 1-800-541-5555 in California, 1-916-636-1200 out-of-state (follow the prompts for eTAR), to notify the sender. Please destroy this document via shredder or confidential destruction.										



# TAR Form Submission

## Submission Method

Providers are encouraged to use electronic TAR (eTAR) submission, which offers faster and more efficient document turn-around and payments. Providers may also submit TARs by mail. All paper TARs must be submitted to the Xerox TAR Processing Center (refer to page 2).

## Submission Locations

Care should be taken to ensure that TAR forms are sent to the West Sacramento TAR Processing Center. To understand which field office adjudicates which services, they are separated into two categories: core services and regionalized services.

### Core Services

- Core services are services that are adjudicated within the geographic area where the provider's service address is located.
- Examples: Elective hospital surgeries, Home Health Agencies, Magnetic Resonance Imaging (MRI) and kidney transplants.

### Regional Services

- Regionalized services are services that are adjudicated only at specified field offices based on the service requested.
- Examples: Nursing facilities (San Bernardino Medi-Cal Field Office), hearing aids, orthotics and prosthetics (Sacramento Medi-Cal Field Office) and Durable Medical Equipment (multiple field offices depending on what is being requested: refer to the *TAR Field Office Addresses* [tar field] section in the Part 2 Provider Manual).

Requests for drug authorizations are faxed to either the Northern or Southern Medi-Cal Pharmacy offices.

## Resource Information

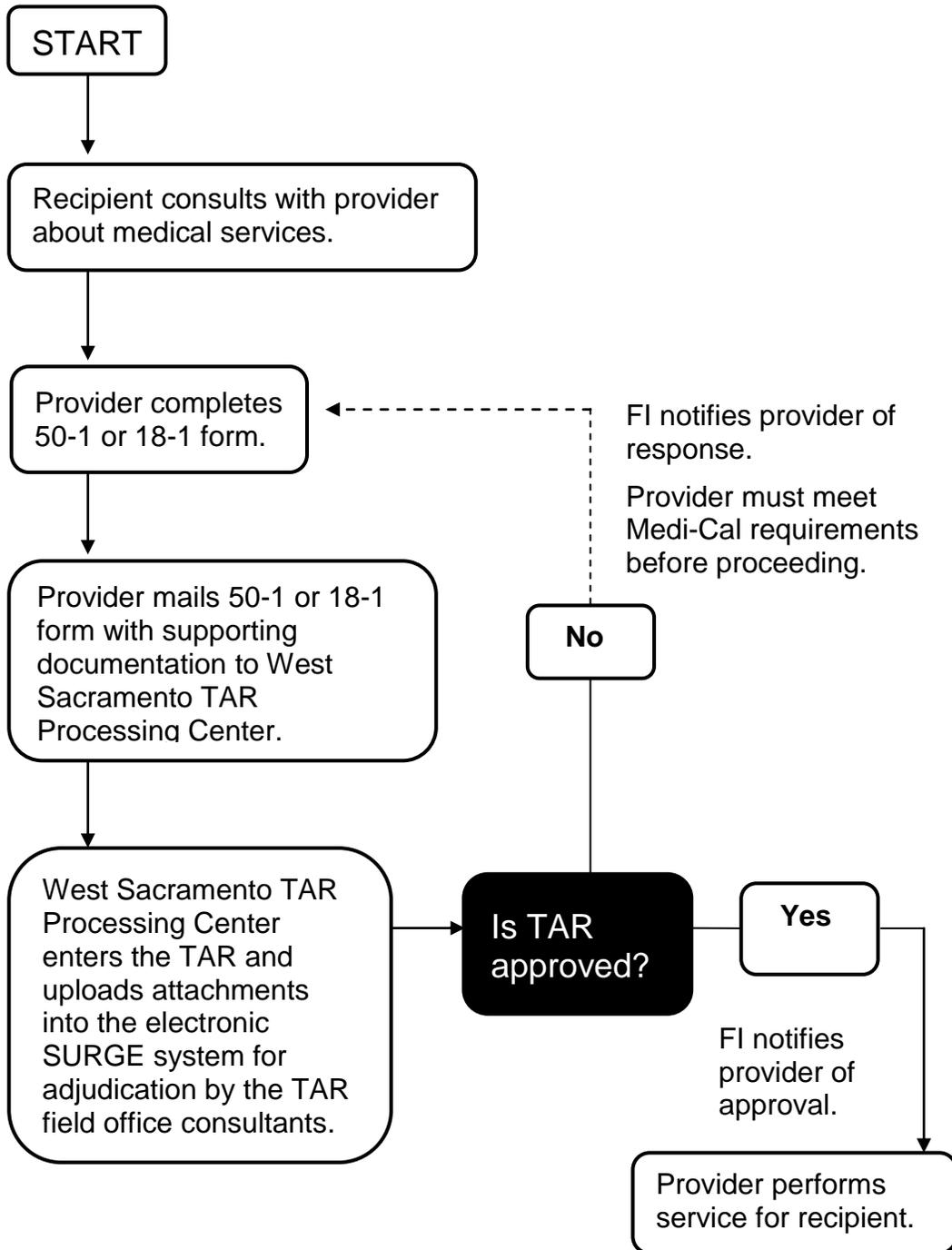
Additional information can be found in the provider manual.

- The *TAR Field Office Addresses* section (tar field) in Part 2 of the provider manual lists the Medi-Cal field offices and the regionalized services for each process.
- For more information about drug TARs, refer to the *TAR Submission: Drug TARs* section (tar sub drug) in the Medi-Cal Pharmacy provider manual.
- Providers may contact the Telephone Service Center (TSC) at 1-800-541-5555 with TAR related inquiries.

# TAR Completion Flowcharts

## Paper TAR Form and Attachment Submission

The flowchart below depicts the process providers use when requesting Medi-Cal authorization to perform medical services with a 50-1 or 18-1 TAR form.



# CMS-1500 Claim Form

## Introduction

### Purpose

The purpose of this module is to provide an overview of the *CMS-1500* claim form. This module presents claim completion, processing instructions and offers participants general billing information.

### Module Objectives

- Identify provider manual sections with *CMS-1500* claim form completion instructions
- Introduce general billing guidelines for the completion and submission of the *CMS-1500* claim form
- Review common claim form completion errors
- Complete sample *CMS-1500* claim form scenarios

### Resource Information

#### **Medi-Cal Subscription Service (MCSS)**

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at ([www.medi-cal.ca.gov/mcss](http://www.medi-cal.ca.gov/mcss)).

#### **Provider Manual References**

##### **Part 1**

*CMC Enrollment Procedures* (cmc enroll)

*Computer Media Claims* (cmc)

##### **Part 2**

*CMS-1500 Completion* (cms comp)

*CMS-1500 Special Billing Instructions* (cms spec)

*CMS-1500 Submission and Timeliness Instructions* (cms sub)

*CMS-1500 Tips for Billing* (cms tips)

#### **Other References**

Medi-Cal Learning Portal e-learning tutorial for *CMS-1500* claim form completion (<http://learn.medi-cal.ca.gov>)

#### **Acronyms**

A list of current acronyms is located in the *Appendix* section of this workbook.

# CMS-1500 Claim Form Description

The Health Insurance Claim form, *CMS-1500*, is used by Allied Health professionals, physicians, laboratories and pharmacies to bill for supplies and services provided to Medi-Cal recipients. Paper or electronic claim forms must be forwarded to the Department of Health Care Services (DHCS) Fiscal Intermediary (FI) for processing within six months following the month in which services were rendered. Exceptions to the six-month billing limit can be made if the reason for the late billing is a delay reason allowed by regulations.

# CMS-1500 Claim Form Guidelines

## Form Submission Methods

### Paper Format

Providers are required to purchase *CMS-1500* (02/12) claim forms from a vendor. The claim forms ordered through vendors must include red “drop-out” ink to meet Centers for Medicare & Medicaid Services (CMS) standards. The following guidelines apply to claim forms submitted by mail:

### Claim Submission Instructions

- Submit one claim form per set of attachments.
- Carbon or photocopies of computer-generated claim form facsimiles or claim forms created on laser printers are unacceptable.
- Do not staple original claims together. Stapling original claims together indicates the second claim is an attachment, not an original claim to be processed separately.
- Undersized attachments must be submitted on 8½ x 11-inch white paper using non-glare tape.

### Form Completion Instructions

- Handwritten claims should be printed neatly using black ballpoint pen ONLY.
- Type all information using capital letters and 10-point font-size or larger for clarity and accuracy.
- Punctuation or symbols (\$, %, &, /, etc.) should only be used in designated areas.
- Type only in areas of the form designated as fields. Data must fall completely within the text space and should be properly aligned.
- Do not use highlighters or correction tapes/fluid on hard copy claim forms or follow-up forms.
- Verify that claim form information is valid and appropriate for the services rendered for the date of service before mailing:
  - Procedure code
  - Modifier (if appropriate)
  - Place of Service
  - Inclusion of ICD Indicator

**Mailing Information**

- Mail *CMS-1500* claim forms to the FI in the blue and white, color-coded envelopes.
- Envelopes are free of charge. Order envelopes by calling the Telephone Service Center (TSC) at 1-800-541-5555.
- Do not fold or crease claim forms to fit into small-sized envelopes.

**Electronic Transmission**

Computer Media Claims (CMC) submission is the most efficient method for billing Medi-Cal. CMC submission offers additional efficiency to providers because these claims are submitted faster and entered into the claims processing system faster.

The ICD version qualifier will be entered in the HI – Health Care Diagnosis Code segment. For Principal Diagnosis, providers enter “BK” to indicate that ICD-10-CM diagnosis codes were entered on the claim.

**Claim Submission Instructions**

The following guidelines apply to claims submitted by electronic transmission:

- Claims may be submitted electronically via CMC telecommunications (modem) or the Medi-Cal website (*www.medi-cal.ca.gov*).
- A *Medi-Cal Telecommunications Provider and Biller Application/Agreement* (DHCS 6153) must be on file with the FI.
- Claims requiring hard copy attachments may be billed electronically, but only if the attachments are submitted according to the instructions for Attachment Control Forms (ACF), as described below.
- Attachment Control Forms must be accompanied by a Medi-Cal claim *Attachment Control Form* (ACF) and mailed or faxed to the FI. The attachments must be completed as specified or the attachments will not be linked with the electronic claim, resulting in claim denial.

**Billing Instructions**

Electronic data specifications and billing instructions are located in the *Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual*.

**Contact Information**

For additional information, contact TSC at 1-800-541-5555.

**NOTES**

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## Additional Forms (Attachments)

### Medi-Cal Claim Attachment Control Form (ACF)

An ACF validates the process of linking paper attachments to electronic claims. Under HIPAA rules, an 837 v.5010 electronic claim cannot be rejected (denied) because it requires an attachment. The California Medicaid Management Information System (CA-MMIS) processes paper attachments submitted in conjunction with an (837 v.5010) electronic claim.

For each electronically submitted claim requiring an attachment, a single and unique ACF must be submitted via mail or fax. Providers will be required to use the 11-digit Attachment Control Number (ACN) from the ACF to populate the Paperwork (PWK) segment of the 837 HIPAA transaction.

Attachments must be mailed or faxed to the FI at the following address or fax number:

Xerox State Healthcare, LLC  
P.O. Box 526022  
Sacramento, CA 95852  
Fax: 1-866-438-9377

#### NOTE

The method of transmission (mail or fax) must be indicated in the appropriate PWK segment and must match the method of transmission used.

### Attachment Policies

The following guidelines apply to attachments submitted with a *CMS-1500* claim form:

- All attachments must be received within 30 days of the electronic claim submission.
- Paper attachments cannot be matched after 30 calendar days.
- To ensure accurate processing, only one ACN value will be accepted per single electronic claim and only one set of attachments will be assigned to a claim.
- Providers should not fax attachments the same day as submitting the claim electronically.

#### NOTE

A 24 hour hold is required before faxing documents when billing electronically.

### Denied Claim Reasons

- If an 837 v.5010 electronic transaction is received that requires an attachment and there is no ACN, the claim will be denied.
- If there is no ACF or a photocopy of an ACF is received by the FI, the attachments or documentation will be returned with a rejection letter to the provider or submitter.
- No photocopies of the ACF will be accepted.
- The method of transmission must match the method of transmission indicated in the PWK segment; otherwise, the attachment will not link up with the claim and it will be denied for no attachment received.
- If documents are faxed the same day a claim is billed electronically, the claim can be denied.

**ACF Order/Reorder Instructions**

To order ACFs, follow the instructions below:

- Call TSC at 1-800-541-5555; or
- Complete and mail the hard copy reorder form.

For further instructions, refer to the *Forms Reorder Request: Guidelines* section (forms reo) in the Part 2 provider manual or visit the Medi-Cal website ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)).

**NOTE**

ACFs and envelopes are provided free of charge to all providers submitting 837 v.5010 electronic transactions.

DO NOT STAPLE  
IN BAR AREA

**MEDI-CAL CLAIM ATTACHMENT CONTROL FORM**  
STATE OF CALIFORNIA      DEPARTMENT OF HEALTH SERVICES

**ATTACHMENT CONTROL NUMBER**      99999999999

**PROVIDER NUMBER :**  (REQUIRED)

**PROVIDER NAME :** \_\_\_\_\_

**PROVIDER ADDRESS :** \_\_\_\_\_

(PLEASE PRINT IN BLACK OR BLUE INK TO COMPLETE THIS FORM)

DO NOT  
WRITE IN  
THIS SPACE

FOR F.I. USE ONLY

1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RETURN THIS FORM WITH ATTACHMENTS TO:

FISCAL INTERMEDIARY

P.O. BOX 526022

SACRAMENTO, CA 95852

PROVIDER SIGNATURE      DATE

X \_\_\_\_\_

USE THIS FORM AS A COVER SHEET FOR PAPER DOCUMENTATION TO SUPPORT THE ELECTRONICALLY SUBMITTED CLAIM.  
FOR FURTHER INFORMATION REGARDING USE OF THE ATTACHMENT CONTROL FORM SEE THE PROVIDER MANUAL.

FORM NUMBER ACF-001

**ACF Example**



Xerox State Healthcare, LLC  
820 Stillwater Road  
West Sacramento, CA 95605

Date:

**ATTACHMENT CONTROL FORM REJECT LETTER**

This letter is to inform you that the coversheet or Attachment Control Form (ACF) you submitted does not meet Medi-Cal standards. It has been rejected for the following reason(s):

\_\_\_\_\_ **Invalid ACF**  
(Only original ACFs provided by California Department of Health Services will be accepted)

\_\_\_\_\_ **Missing ACF**  
(Paper attachments submitted without ACF)

\_\_\_\_\_ **Supporting documentation missing**  
(ACF received without paper attachments)

\_\_\_\_\_ **Invalid Attachment Control Number (ACN) on ACF**  
(Pre-imprinted CANNOT be altered or unreadable)

\_\_\_\_\_ **Other:** \_\_\_\_\_

Please resubmit your electronic claim if:

The resubmitted ACF has an Attachment Control Number (ACN) that differs from your original electronic claim form or;

More than 30 days have passed since you originally submitted your electronic claim.

Mail Attachments to - Fiscal Intermediary  
P.O. Box 526022  
Sacramento, CA 95852

If you have any questions regarding this notice or submitting attachments, please call the Telephone Service Center at 1-800-541-5555.

Sincerely,

**ACF Rejection Letter**

# CMS-1500 Claim Form Completion

## CMS-1500 Claim Form (Fields 1 – 13)

The *CMS-1500* claim form is a national form; therefore, many fields are not required by Medi-Cal. Field-by-field instructions for completing the *CMS-1500* claim form are in the *CMS-1500 Completion* section (cms comp) of the appropriate Part 2 provider manual.

HEALTH INSURANCE CLAIM FORM									
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12									
PICA <input type="checkbox"/>								PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#)</small>				3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER <small>(For Program in Item 1)</small>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)				8. RESERVED FOR NUCC USE		7. INSURED'S ADDRESS (No., Street)			
CITY		STATE		CITY		STATE		CITY	
ZIP CODE		TELEPHONE (Include Area Code) ( )		ZIP CODE		TELEPHONE (Include Area Code) ( )		ZIP CODE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>			
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____		b. OTHER CLAIM ID (Designated by NUCC)			
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>			
<p align="center"><b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b></p> 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.									
SIGNED _____				DATE _____		SIGNED _____			

**Sample Partial CMS-1500 Claim Form**

### NOTES

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## Field Descriptions: 1 – 5

Box #	Field Name	Instructions
1	MEDICAID/ MEDICARE/ OTHER ID	For Medi-Cal, enter an "X" in the <i>Medicaid</i> box.  <b>Billing Tip:</b> When billing Medicare crossover claims, check both the _____ and _____ boxes.
1A	INSURED'S ID NUMBER	Enter the recipient's ID number from the Benefits Identification Card (BIC). Do not enter the Medicare ID number unless it is a crossover. When submitting a claim for a newborn, enter mother's ID number in this field.  <b>Billing Tip:</b> Use the _____ to verify that the recipient is eligible for the services rendered.
2	PATIENT'S NAME	Enter the recipient's last name, first name and middle initial (if known). Avoid nicknames or aliases.  <i>A comma is required between recipient's last name, first name and middle initial (if known).</i>  <b>Billing Tip – Newborn Infant:</b> When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name in Box 2. If the infant has not been named, write the mother's last name followed by _____ or _____.
3	PATIENT'S BIRTH DATE/SEX	Enter the recipient's date of birth in six-digit MMDDYY format (month, day, year). If the recipient is 100 years or older, enter the recipient's age and the full four-digit year of birth in Box 19. Enter an "X" in the M or F box (as shown on the BIC).  <b>Billing Tip – Newborn Infant:</b> Enter the infant's sex and date of birth in Box 3.
4	INSURED'S NAME	<i>Not required by Medi-Cal, except when billing for a newborn using the mother's ID.</i> Enter the mother's name in this field when billing for the newborn.  <b>Billing Tip – Newborn Infant:</b> Enter the _____ in the <i>Insured's Name</i> field (Box 4).
5	PATIENT'S ADDRESS AND TELEPHONE	Enter the recipient's complete address and telephone number.

## Field Descriptions: 6 – 11D

Box #	Field Name	Instructions
6	PATIENT'S RELATIONSHIP TO INSURED	<i>Not required by Medi-Cal.</i> This field should be used when billing for an infant using the mother's ID by checking the <i>Child</i> box.
10A	EMPLOYMENT	Complete this field if services were related to an accident or injury. <ul style="list-style-type: none"> <li>• Enter an "X" in the <i>Yes</i> box if accident/injury is employment related.</li> <li>• Enter an "X" in the <i>No</i> box if accident/injury is not employment related.</li> </ul> If either box is checked, the date of the accident must be entered in the <i>Date of Current Illness, Injury or Pregnancy</i> field (Box 14).
10D	CLAIM CODES (Designated by NUCC)	Enter the amount of recipient's Share of Cost (SOC) for the procedure, service or supply. Do not enter a decimal point (.) or dollar sign (\$). Enter the full dollar amount including cents, even if the amount ends in zeros (e.g. if SOC collected/obligated is \$100, enter 10000, not 100).
11D	ANOTHER HEALTH BENEFIT PLAN	Enter an "X" in the <i>Yes</i> box if the recipient has Other Health Coverage (OHC). Enter the amount paid (without the dollar or decimal point) by the other health insurance in the right side of Box 11D.  <b>Billing Tip:</b> Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient's _____ prior to billing Medi-Cal. Eligibility under Medicare or Medi-Cal Managed Care Plan (MCP) is not considered OHC.

**Answer Key:** 1) Medicaid, Medicare; 1A) POS network; 2) BABY BOY, BABY GIRL; 4) mother's name; 11D) other health coverage

### CMS-1500 Claim Form (Fields 14 – 33)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.			15. OTHER DATE QUAL. MM DD YY			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						17a. _____	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY										
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						17b. NPI _____	20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. L. _____ B. L. _____ C. L. _____ D. L. _____ E. L. _____ F. L. _____ G. L. _____ H. L. _____ I. L. _____ J. L. _____ K. L. _____ L. L. _____						ICD Ind. _____	22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____										
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	
1																	
2																	
3																	
4																	
5																	
6																	
25. FEDERAL TAX I.D. NUMBER			SSN	EIN	26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. Rsvd for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)						32. SERVICE FACILITY LOCATION INFORMATION						33. BILLING PROVIDER INFO & PH # ( )					
SIGNED			DATE			a. NPI			b. NPI			a. NPI		b. NPI			

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample: Partial CMS-1500 Claim Form

## Field Descriptions: 14 – 20

Box #	Field Name	Instructions
14	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP)	Enter the date of the onset of the recipient's illness, the date of accident/injury or the date of the Last Menstrual Period (LMP).
17	NAME OF REFERRING PROVIDER OR OTHER SOURCE	Must indent text two bytes. Enter the name of the referring provider in this box. When the referring provider is a non-physician medical practitioner (NMP) working under the supervision of a physician, the name of the NMP must be entered. However, the NPI of the supervising physician needs to be entered in box 17B, below.
17B	NPI (OF REFERRING PHYSICIAN)	Enter the 10-digit NPI. The following providers must complete Box 17 and Box 17B: <ul style="list-style-type: none"> <li>• Audiologist</li> <li>• Clinical laboratory (services billed by laboratory)</li> <li>• Durable Medical Equipment (DME) and medical supply</li> <li>• Hearing aid dispenser</li> <li>• Nurse anesthetist</li> <li>• Occupational therapist</li> <li>• Orthotist</li> <li>• Pharmacy</li> <li>• Physical therapist</li> <li>• Podiatrist (services are rendered in a Skilled Nursing Facility [NF] Level A or B)</li> <li>• Portable X-ray</li> <li>• Prosthetist</li> <li>• Radiologist</li> <li>• Speech pathologist</li> </ul>
18	HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	Enter the dates of hospital admission and discharge if the services are related to hospitalization. If the patient has not been discharged, leave the discharge date blank.
19	ADDITIONAL CLAIM INFORMATION (Designated by NUCC)	Use this area for procedures that require additional information, justification or an <i>Emergency Certification Statement</i> .  <b>Billing Tip:</b> "By Report" codes, complicated procedures, unlisted services and anesthesia time require _____. Box 19 may be used if space permits. Please do not staple attachments.
20	OUTSIDE LAB?	If this claim includes charges for laboratory work performed by a licensed laboratory, enter an "X." Outside laboratory refers to a lab not affiliated with the billing provider. Indicate in Box 19 that a specimen was sent to an unaffiliated laboratory. Leave blank, if not applicable.

Answer Key: 19) attachments;

## Field Descriptions: 21 – 24B

Box #	Field Name	Instructions
21	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	Claims with a diagnosis code must include the ICD indicator "0". Claims that do not include the ICD indicator will be returned via the <i>Resubmission Turnaround Document</i> (Form 65-1). Medi-Cal requires providers to enter the ICD indicator "0".  <b>ICD Ind.</b> Enter the ICD indicator "0" for claims submitted with a date of service on or after October 1, 2015. Claims submitted without a diagnosis code do not require an ICD indicator.
21.A	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter all letters and/or numbers of the ICD-10-CM diagnosis code for the <u>primary</u> diagnosis, including fourth through seventh characters, if present. (Do <u>not</u> enter decimal point.)
21.B	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	If applicable, enter all letters and/or numbers of the <u>secondary</u> ICD-10-CM diagnosis code, including fourth through seventh characters, if present. (Do <u>not</u> enter decimal point.)
21.C-L	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Not required by Medi-Cal.  Medi-Cal only accepts ____ diagnosis codes. Codes entered in Boxes 21.C-L will not be used for claims processing.
22	RESUBMISSION CODE	Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional.
23	PRIOR AUTHORIZATION NUMBER	Physician and podiatry services requiring a <i>Treatment Authorization Request</i> (TAR) must enter the 11-digit TAR Control Number (TCN). It is not necessary to attach a copy of the Adjudication Response to the claim. For California Children's Services (CCS) claims, enter the 11-digit Service Authorization Request (SAR) number.  <b>Billing Tip:</b> Recipient information on the claim must match the _____. Only one TCN can cover the services billed on any one claim.
24A	DATE(S) OF SERVICE	Enter the date the service was rendered in the <i>From</i> and <i>To</i> boxes in the six-digit, MMDDYY (month, day, year) format in the unshaded area. When billing for a single date of service, enter the date in <i>From</i> box in Field 24A.
24B	PLACE OF SERVICE	Enter the two-digit national Place of Service code in the unshaded area, indicating where the service was rendered.  <b>Billing Tip:</b> The national Place of Service codes are listed in the _____ section in the appropriate Part 2 provider manual.

**Answer Key:** 21.C-L) two, 23) TAR/SAR; 24B) CMS-1500 Completion

## Field Descriptions: 24C – 24J

Box #	Field Name	Instructions
24C	EMG	<p>Emergency or Delay Reason Codes.</p> <p><b>Delay Reason Code:</b> If there is no emergency indicator in Box 24C, enter a delay reason code in the unshaded portion of the box. Only one delay reason code is allowed per claim. If more than one is present, the first occurrence will be applied to the entire claim.</p> <p><b>Emergency Code:</b> Only one emergency indicator is allowed per claim, and must be placed in the bottom-unshaded portion of Box 24C. Leave this box blank unless billing for emergency services. Enter "X" if an Emergency Certification Statement is attached to claim or entered in Box 19.</p>
24D	PROCEDURES, SERVICES OR SUPPLIES/ MODIFIER	<p>Enter the appropriate procedure code (CPT-4 or HCPCS) and modifier(s).</p> <p><b>Billing Tip:</b> The descriptor for the procedure code must match the procedure performed, and the modifier(s) must be billed appropriately. Do not submit multiple _____ on the same claim line. If necessary, the procedure description can be entered in the <i>Additional Claim Information</i> field (Box 19).</p> <p><b>Billing Tip:</b> <u>Do not submit a National Correct Coding Initiative (NCCI)-associated modifier in the first position (right next to the procedure code) on a claim, unless it is the only modifier being submitted.</u></p>
24E	DIAGNOSIS POINTER	As required by Medi-Cal.
24F	\$ CHARGES	In the unshaded area of the form, enter the usual and customary fee for service(s) in full dollar amount. Do not enter a decimal point (.) or dollar sign (\$). For example, \$100 should be entered as "10000."
24G	DAYS OR UNITS	<p>Enter the number of medical "visits" or procedures, surgical "lesions," hours of "detention time," units of anesthesia time, items or units of service, etc. The field permits entries up to 999 in the unshaded area.</p> <p><b>Billing Tip:</b> Providers billing for units of time should enter the time in _____. For example, one hour should be entered as "4."</p>
24H	EPSDT FAMILY PLAN	<p>Enter code "1" or "2" if the services rendered are related to family planning (FP). Enter code "3" if the services rendered are Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable.</p> <p><b>Billing Tip:</b> Refer to the <i>Family Planning</i> section (fam planning) of the appropriate Part 2 provider manual for additional details.</p>
24J	RENDERING PROVIDER ID #	<p>Enter the NPI for a rendering provider (unshaded area) if the provider is billing under a group NPI.</p> <p><b>Billing Tip:</b> If an error has been made to specific billing information entered on items 24A – 24J, draw a line through the entire detail using a blue or black ballpoint pen. Enter the <u>correct</u> billing information on another line. Do not _____ the entire claim line. Deleted information may be used to determine previous payment.</p>

Answer Key: 24D) NCCI associated modifiers; 24G) 15-min. increments; 24J) black out

## Field Descriptions: 28 – 33B

Box #	Field Name	Instructions
28	TOTAL CHARGE	Enter the full dollar amount for all services without the decimal point (.) or dollar sign (\$). For example, \$100 should be entered as "10000."
29	AMOUNT PAID	Enter the full dollar amount of payments(s) received from the Other Health Coverage (Box 11D) and/or patient's Share of Cost (Box 10D), without the decimal point (.) or dollar sign (\$).  <b>Billing Tip:</b> Do not enter Medicare payments in this box. The Medicare payment amount will be calculated from the Medicare EOMB/MRN/RA when submitted with the claim.
30	Rsvd for NUCC Use	Effective for dates of service on or after October 1, 2014, this box is no longer required to be completed.
31	SIGNATURE OF PHYSICIAN OR SUPPLIER...	The claim must be signed and dated by the provider or a representative assigned by the provider, in black ballpoint pen only.  <b>Billing Tip:</b> Signatures must be _____, not printed and should not extend outside the box. Stamps, initials or facsimiles are not accepted.
32	SERVICE FACILITY LOCATION INFORMATION	Enter the provider name. Enter the provider's address, without a comma between the city and state, including the nine-digit ZIP Code, without a hyphen.  <b>Billing Tip:</b> Use the name and address of the facility where the services were rendered if other than a _____ or _____.
32A	(blank)	Enter the NPI of the facility where the services were rendered.
32B	(blank)	Enter the Medi-Cal provider number for an atypical service facility.
33	BILLING PROVIDER INFO AND PHONE NUMBER	Enter the provider name. Enter the provider address, without a comma between the city and state, including the nine-digit ZIP Code, without a hyphen. Enter the telephone number.
33A	(blank)	Enter the billing provider's NPI.
33B	(blank)	Used for atypical providers only. Enter the Medi-Cal provider number for the billing provider.  <b>Billing Tip:</b> Do not submit claims using a Medicare provider number or state license number. Claims from providers and/or billing services that consistently bill numbers other than the NPI (or Medi-Cal provider number for atypical providers) will be denied.

HEALTH INSURANCE CLAIM FORM												
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12												
PICA <input type="checkbox"/>										PICA <input type="checkbox"/>		
1. MEDICARE <input type="checkbox"/> (Medicare#)	MEDICAID <input checked="" type="checkbox"/> (Medicaid#)	TRICARE <input type="checkbox"/> (ID#/DoD#)	CHAMPVA <input type="checkbox"/> (Member ID#)	GROUP HEALTH PLAN <input type="checkbox"/> (ID#)	FECA BLK LUNG <input type="checkbox"/> (ID#)	OTHER <input type="checkbox"/> (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)		9000000A95001			
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE		SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
DOE, JANE				06 21 90		M <input type="checkbox"/> F <input checked="" type="checkbox"/>						
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED				7. INSURED'S ADDRESS (No., Street)				
1234 MAIN STREET				Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>								
CITY			STATE			CITY			STATE			
ANYTOWN			CA									
ZIP CODE		TELEPHONE (Include Area Code)		ZIP CODE		TELEPHONE (Include Area Code)						
95823-5555		(916) 555-5555				( )						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous)				a. INSURED'S DATE OF BIRTH				
				<input type="checkbox"/> YES <input type="checkbox"/> NO				MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? PLACE (State)				b. OTHER CLAIM ID (Designated by NUCC)				
				<input type="checkbox"/> YES <input type="checkbox"/> NO								
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT?				c. INSURANCE PLAN NAME OR PROGRAM NAME				
				<input type="checkbox"/> YES <input type="checkbox"/> NO								
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? 25000				
								<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO // yes, complete items 9, 9a, and 9d.				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.												
SIGNED _____ DATE _____						SIGNED _____						
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)				15. OTHER DATE				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				
MM DD YY QUAL				MM DD YY QUAL				FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. _____				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				
				17b. NPI 0123456789				FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)						20. OUTSIDE LAB? \$ CHARGES						
PLEASE SEE ATTACHED OPERATIVE REPORT						<input type="checkbox"/> YES <input type="checkbox"/> NO						
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0												
A. D1D1D1D	B. D2D2D2D	C. _____	D. _____	E. _____	F. _____	G. _____	H. _____	I. _____	J. _____	K. _____	L. _____	
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS		F. \$ CHARGES		
From MM DD YY To MM DD YY		CPT/HCPCS MODIFIER		DIAGNOSIS POINTER		G. DAYS OF UNITS		H. EPCS/OT Family Plan		I. ID. QUAL		
06 07 16		21		42500 AG		200000		1		NPI 1234567890		
06 07 16		21		42300 51		50000		1		NPI 1234567890		
										NPI		
										NPI		
										NPI		
										NPI		
										NPI		
										NPI		
25. FEDERAL TAX I.D. NUMBER			SSN EIN			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? (For gov. claims, see back)		28. TOTAL CHARGE	
									<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ 250000	
											\$ 25000	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			32. SERVICE FACILITY LOCATION INFORMATION			33. BILLING PROVIDER INFO & PH #						
SIGNED Jane Doe			DOWNTOWN HOSPITAL 102 FIRST STREET ANYTOWN, CA 958235555			JANE SMITH 1027 MAIN STREET ANYTOWN, CA 958235555			(916) 555-5555			
DATE 06/30/16			a. 2345678901			b. _____			a. 3456789012			
									b. _____			

CMS-1500 Claim Form with Other Health Coverage.

**NOTE**  
Claim(s) should be submitted directly to the FI for processing.

# Learning Activities

## Learning Activity 1: Common Claim Completion Errors

### Brainteaser

What is wrong with this claim?

HEALTH INSURANCE CLAIM FORM												
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12												
PICA <input type="checkbox"/>										PICA <input type="checkbox"/>		
1. MEDICARE <input checked="" type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK/LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)						1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>90000000A</b>						
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>Luke Out</b>				3. PATIENT'S BIRTH DATE MM DD YY M <input checked="" type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
5. PATIENT'S ADDRESS (No., Street) <b>1234 JELLY BEAN COURT</b>				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)						
CITY <b>ANYTOWN</b>			STATE <b>CA</b>			CITY			STATE			
ZIP CODE <b>96670</b>			TELEPHONE (Include Area Code) <b>(916) 454-5555</b>			ZIP CODE			TELEPHONE (Include Area Code) ( ) ( )			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER				10d. CLAIM CODES (Designated by NUCC) <b>4.00</b>				d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>				
b. RESERVED FOR NUCC USE				12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____				
c. RESERVED FOR NUCC USE				14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____				15. OTHER DATE QUAL. _____ MM DD YY				
d. INSURANCE PLAN NAME OR PROGRAM NAME				17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. NPI <b>0123456789</b>				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. <b>D1D1D1D</b> B. <b>D2D2D2D</b> C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____				22. RESUBMISSION CODE ORIGINAL REF. NO.				23. PRIOR AUTHORIZATION NUMBER				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		J. RENDERING PROVIDER ID. #		
1 <b>10 05 15</b>		<b>22</b>		<b>36780</b>				<b>\$625 00</b>		<b>1</b> NPI		
2										NPI		
3										NPI		
4										NPI		
5										NPI		
6										NPI		
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>			26. PATIENT'S ACCOUNT NO.			27. ACCEPT ASSIGNMENT? For 9911 claims, use 99250 <input type="checkbox"/> YES <input type="checkbox"/> NO			28. TOTAL CHARGE \$ <b>625 00</b>		29. AMOUNT PAID \$ <b>625 00</b>	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  <i>Polly Ester</i> SIGNED DATE <b>06/30/13</b>			32. SERVICE FACILITY LOCATION INFORMATION a. <b>NPI</b> b. _____			33. BILLING PROVIDER INFO & PH # <b>(916) 861-4539</b> <b>CLARA FIE</b> <b>343 MAIN STREET</b> <b>CHERRY CITY, CA</b> a. <b>234567890</b> b. _____						

## Learning Activity 1: Answer Key

Box #	Current Data Entries	Correct Entries
1	Medicare <i>(checked)</i>	The Medicaid box should be marked.
1A	90000000A	A 14-digit ID number must be indicated.
2	Luke Out	OUT, LUKE (last name, first, middle initial) The name must be in all caps.
3	(blank)	Recipient's date of birth must be indicated using six-digit (MMDDYY) format.
10D	4.00	Do <u>not</u> use dollar signs or decimals.
17B	(blank)	This field must indicate NPI of referring physician.
21	ICD Ind. (blank)	0
24D	36780	This field requires an appropriate modifier for procedure code.
24F	\$62500	Do <u>not</u> use dollar signs or decimals.
27	(blank)	Select "YES" to accept assignment.
29	(blank)	The claim must indicate SOC dollar amount collected (400).
30	62500	Effective for dates of service on or after October 1, 2014, this box is no longer required to be completed.
32	(blank)	Facility name, address and NPI
32A	(blank)	Enter 10-digit NPI number.
33	<i>(ZIP code missing)</i>	The nine-digit ZIP code of the billing provider is required without a hyphen.
33A	234567890	Enter the NPI number, which must be 10-digits.

### NOTES

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## Learning Activity 2: Complete It, Submit It, Get Paid

### Scenario

The following procedures were performed on June 21, 2016.

#### Patient Information

Patient (Recipient): Owen Cash  
Birth Date: August 24, 2007  
Address: 123 Summertime Street, Anywhere, CA 98870-4567  
Phone Number: 916-123-5555  
Medi-Cal Id Number: 90000000A95001

#### Procedure Information

- Primary Procedure: Plastic repair of cleft lip/nasal deformity, primary bilateral, one-stage procedure
- Secondary Procedure: Tympanostomy (requiring insertion of ventilating tube), also bilateral. Modifier 50 will be billed to identify a bilateral procedure that is more complex and/or requires additional significant time at a single operative session.
- Location Of Service: Outpatient Hospital (22)
- Diagnosis Codes: D1D1D1D (primary) and D2D2D2D (secondary)
- Referring Physician: Dr. Justin Case, NPI# 1234567890

#### Billing Information

- Primary Procedure: The repair of deformity (primary procedure) will be billed using code 40701 with modifier AG (primary surgeon). As the primary surgery, modifier 50 is not necessary with this code. The usual & customary charge is \$4,120.00. Enter a "1" in the *Days/Units* field (Box 24G).
- Multiple Procedures: The tympanostomy will be billed using code 69436 with modifier 51 (multiple procedures). The usual and customary charge is \$600.00. Enter a "1" in the *Days/Units* field (Box 24G).
- Bilateral Procedure: The tympanostomy will be billed a second time, with modifier 50 (bilateral procedure) to signify the additional time required, at the usual and customary charge of \$600.00. Enter a "1" in the *Days/Units* field (Box 24G).
- Total Charges: \$5320.00
- Balance Due: \$5320.00
- Signature of Physician/Designee: Polly Ester
  - Biller's Name/Address: Penny Sillen, MD (916) 555-1234
  - 201 Circle Lane
  - Rio Meadow, CA 98765-3365
  - NPI# 2234566789

#### NOTE

Always remember to remove dollar signs (\$), decimal points (.) and hyphens (-) from ZIP codes when entering data into claim forms.

# CMS-1500 Claim Form

HEALTH INSURANCE CLAIM FORM												
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12												
<input type="checkbox"/> PICA					PICA <input type="checkbox"/>							
1. MEDICARE <input type="checkbox"/> (Medicare#)                    MEDICAID <input checked="" type="checkbox"/> (Medicaid#)                    TRICARE <input type="checkbox"/> (ID#/DoD#)                    CHAMPVA <input type="checkbox"/> (Member ID#)                    GROUP HEALTH PLAN <input type="checkbox"/> (ID#)                    FECA BLK LUNG <input type="checkbox"/> (ID#)                    OTHER <input type="checkbox"/> (ID#)					1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>90000000A95001</b>							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>CASH, OWEN</b>					3. PATIENT'S BIRTH DATE    SEX MM DD YY    M <input checked="" type="checkbox"/> F <input type="checkbox"/> <b>08 24 07</b> M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) <b>1234 SUMMERTIME ST</b>					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY <b>ANYWHERE</b>		STATE <b>CA</b>			8. RESERVED FOR NUCC USE		CITY		STATE			
ZIP CODE <b>988704567</b>		TELEPHONE (Include Area Code) <b>( 916 ) 123-5555</b>			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH    SEX MM DD YY    M <input type="checkbox"/> F <input type="checkbox"/>		b. OTHER CLAIM ID (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME			
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT?    PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO			c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			10d. CLAIM CODES (Designated by NUCC)		SIGNED _____		DATE _____			
d. INSURANCE PLAN NAME OR PROGRAM NAME		READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		SIGNED _____		DATE _____			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY    QUAL.		15. OTHER DATE MM DD YY    QUAL.			16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY    TO MM DD YY		17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>JUSTIN CASE MD</b>		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY    TO MM DD YY			
17a. _____		17b. NPI <b>1234567890</b>			19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB?    \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)    ICD Ind. <b>0</b>			
A. <b>D1D1D1D</b> B. <b>D2D2D2D</b> C. _____    D. _____		E. _____    F. _____    G. _____    H. _____			I. _____    J. _____    K. _____    L. _____		22. RESUBMISSION CODE    ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER			
24. A. DATE(S) OF SERVICE From MM DD YY    To MM DD YY		B. PLACE OF SERVICE EMG	C. _____		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS    MODIFIER		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. ICD-9-CM Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 <b>06 21 16</b> <b>22</b> <b>40701</b> <b>AG</b> <b>412000</b> <b>1</b> NPI												
2 <b>06 21 16</b> <b>22</b> <b>69436</b> <b>51</b> <b>60000</b> <b>1</b> NPI												
3 <b>06 21 16</b> <b>22</b> <b>69436</b> <b>50</b> <b>60000</b> <b>1</b> NPI												
4 _____    _____    _____    _____    _____    _____    _____    _____    _____    _____												
5 _____    _____    _____    _____    _____    _____    _____    _____    _____    _____    _____												
6 _____    _____    _____    _____    _____    _____    _____    _____    _____    _____    _____												
25. FEDERAL TAX I.D. NUMBER    SSN EIN		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>532000</b>		29. AMOUNT PAID \$ _____		30. Rsvd for NUCC Use		
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  SIGNED <i>Polly Ester</i> DATE <b>07/01/16</b>					32. SERVICE FACILITY LOCATION INFORMATION <b>201 CIRCLE LANE</b> <b>RIO MEADOW, CA 98765-3365</b>			33. BILLING PROVIDER INFO & PH # <b>( 916 ) 555-1234</b> <b>PENNY SILLEN, MD</b> <b>RIO MEADOW, CA</b> <b>98765-3365</b>				
a. <b>9876543210</b>					b. _____		a. <b>2234566789</b>		b. _____			

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)    PLEASE PRINT OR TYPE    CR061653    APPROVED OMB-0938-1197 FORM 1500 (02-12)



# UB-04 Claim Form

## Introduction

### Purpose

The purpose of this module is to provide participants with detailed information about the completion of the *UB-04* claim form for Medi-Cal services. Claim completion requirements, claim information and detailed examples will be discussed for the *UB-04* claim form.

### Module Objectives

- Identify the provider manual sections regarding *UB-04* claim form completion
- Outline Diagnosis-Related Groups (DRG) Reimbursement
- Introduce general completion and submission billing guidelines for the *UB-04* claim form
- Understand claim form differences between inpatient and outpatient services
- Discuss common claim errors (billing tips)
- Complete sample inpatient and outpatient claim forms (learning activities)

## Resource Information

### **Medi-Cal Subscription Service (MCSS)**

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at ([www.medi-cal.ca.gov/mcss](http://www.medi-cal.ca.gov/mcss)).

### **References**

The following reference materials provide Medi-Cal claim submission information.

#### **Provider Manual References**

##### Part 2

*Forms: Legibility and Completion Standards (forms leg)*

*UB-04 Completion: Inpatient Services (ub comp ip)*

*UB-04 Completion: Outpatient Services (ub comp op)*

*UB-04 Special Billing Instructions for Inpatient Services (ub spec ip)*

*UB-04 Tips for Billing: Inpatient Services (ub tips ip)*

*UB-04 Tips for Billing: Outpatient Services (ub tips op)*

#### **Other References**

- Medi-Cal website ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov))
- UB-04 Claim Form Tutorial (<https://learn.medi-cal.ca.gov/training.aspx>)

### **Acronyms**

A list of current acronyms is located in the *Appendix* section of this workbook.

# Diagnosis-Related Groups Reimbursement

Payments for inpatient general acute care for many hospitals are calculated using an all patient refined diagnosis-related groups (APR-DRG) reimbursement methodology. For the purposes of this module, APR-DRG is referred to as the DRG reimbursement method or the DRG model.

It is important inpatient providers know their reimbursement method because it affects payment and claim completion standards. For example, claims submitted by hospitals reimbursed according to the DRG model should take extra care to enter all ICD-10-CM diagnosis codes and ICD-10 PCS codes on a claim to ensure payment at the appropriate level. For help understanding the DRG model, refer to the *Diagnosis-Related Groups (DRG): Inpatient Services* section of the Part 2 Inpatient Services manual.

## **Non-DRG Hospitals**

Non-DRG reimbursed hospitals are hospitals that are not paid according to the DRG reimbursement methodology. Refer to the *Hospital Directory* section of the Part 2 Inpatient Services manual for a listing of non-DRG hospitals. Reimbursement for those hospitals may pertain to certified public expenditure (CPE). Listings in the section are subject to change and may be incomplete.

## **NOTE**

For DRG-related questions, comments and concerns, or to subscribe to the DRG listserv, please send an email to [DRG@dhcs.ca.gov](mailto:DRG@dhcs.ca.gov).

# UB-04 Claim Form Description

The *UB-04* claim form is used to request reimbursement for services rendered by the following institutions:

- Inpatient hospital facilities, such as medical/surgical intensive care, burn care, coronary care and ancillary charges (such as labor and delivery, anesthesiology and central services and supplies)
- Outpatient institutional facilities, such as outpatient departments, rural health clinics, chronic dialysis services and community based adult services

After a *UB-04* claim has been submitted, it must be received by the Department of Health Care Services (DHCS) Fiscal Intermediary (FI) within a specified time frame in order to qualify for reimbursement. The time frames are very specific and need to be adhered to so that providers can receive timely reimbursement. Claims that have been improperly completed will be denied.

# UB-04 Claim Form Completion Guidelines

## Form Submission Method

### Paper Format

The following guidelines apply to claim forms submitted by mail:

### Submission Instructions

- Bill in the Medi-Cal format. Follow claim form completion instructions outlined in the *UB-04 Completion: Inpatient Services* or *UB-04 Completion: Outpatient Services*.
- Send original claims only (printed with red “drop-out” ink).
- Photocopies, carbon copies and computer-generated claim form facsimiles are unacceptable.
- Submit separate claim forms for inpatient services. Do not combine inpatient and outpatient services on the same claim form.
- Separate individual claim forms. Do not staple original claims together. Stapling original claims together indicates the additional claims are attachments, not original claims that need to be processed.
- Submit one claim form per set of attachments.
- Tape undersized attachments to 8½ by 11-inch white paper using non-glare tape.
- Do not use colored paper.
- Ensure that a valid CPT-4/HCPCS code is used for the date of service. In addition, make sure that the revenue code is valid and on file.
- Appropriate modifiers must be used when billing for surgical, pathology, radiology and some medicine codes.

## Form Completion Instructions

- Handwritten claims should be printed neatly using black ballpoint pen ONLY.
- Only typed, handwritten or computer-printed forms can be scanned by Optical Character Recognition (OCR) equipment.
  - Type all information using capital letters on forms.
  - For best possible clarity and accuracy, use 10-pt. pica type, six lines per inch. Do not use script or italic font.
- Data must fall completely within the text space and should be properly aligned.
- Undesignated white space (such as Box 2) and undesignated shaded areas or areas labeled “FOR F.I. USE ONLY” should be left blank. These areas are reserved for FI use only.
- Punctuation or symbols (\$, %, &, /, etc.) must not be used except in designated areas.
- Do not use highlighters or correction tape/fluid on the hard copy claim or follow-up form.
- Strike out incorrect information by drawing a line through the entire detail line from the left border of the *Revenue Code* field (Box 42) to the right border of Box 49. Enter the correct billing information on another detail line.

## Mailing Instructions

- To expedite the sorting and preparation of claims for scanning, do not fold or crease forms to fit into small-sized envelopes. Enclose forms in full-sized, color-coded envelopes supplied at no charge by the FI.

## Electronic Transmission

Computer Media Claims (CMC) submission is the most efficient method of Medi-Cal billing. CMC submission offers additional efficiency to providers because these claims are submitted faster and entered into the claims processing system faster.

The following guidelines apply to claim forms submitted by electronic transmission:

## Submission Instructions

- Claims may be submitted electronically via CMC telecommunications (modem) or Medi-Cal website ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)).
- Claims requiring hard copy attachments may be billed electronically.
- Attachments must be accompanied by a *Medi-Cal Claim Attachment Control Form* (ACF) and mailed or faxed to the FI. The attachments must be completed as specified or the attachments will not be linked with the electronic claim, resulting in claim denial.

## Billing Instructions

Electronic data specifications and billing instructions are located in the *Medi-Cal CMC Billing and Technical Manual*.

## Contact Information

For additional information, contact the Telephone Service Center (TSC) at 1-800-541-5555.

## Medi-Cal Claim Attachment Control Form (ACF)

An ACF makes it possible to process paper attachments. Under HIPAA rules, an 837 v.5010 electronic claim cannot be rejected (denied) because it requires an attachment. The California Medicaid Management Information System (CA-MMIS) has been modified to process paper attachments submitted in conjunction with an (837 v.5010) electronic claim.

For each electronically submitted claim requiring an attachment, a single and unique ACF must be submitted via mail or fax. Providers will be required to use the 11-digit Attachment Control Number (ACN) from the ACF to populate the Paperwork (PWK) segment of the 837 HIPAA transaction.

Attachments must be mailed or faxed to the address below:

Xerox State Healthcare, LLC  
P.O. Box 526022  
Sacramento, CA 95852  
Fax: 1-866-438-9377

The following guidelines apply to attachments submitted with *UB-04* claim forms.

### Attachment Policies

- All attachments must be received within 30 days of the electronic claim submission.
- Paper attachments cannot be matched after 30 calendar days.
- To ensure accurate processing, only one ACN value will be accepted per single electronic claim and only one set of attachments will be assigned to a claim.

### Denied Claim Reasons

- If an 837 v.5010 electronic transaction is received that requires an attachment and there is no ACN, the claim will be denied.
- If no ACF or a non-original ACF is submitted, the attachments or documentation will be returned with a reject letter to the provider or submitter.
- No photocopies of the ACF will be accepted.
- The method of transmission must match the method of transmission indicated in the PWK segment; otherwise, the attachment will not link up with the claim and it will be denied because no attachment was received.

### ACF Order/Reorder Instructions

To place an order for ACFs or reorder forms, follow the instructions below:

- To order ACF documents, call the TSC at 1-800-541-5555.
- To reorder forms, complete and mail the hard copy reorder form.

For more information regarding ACFs, refer to the *Forms Reorder Request: Guidelines* section (forms reo) in the Part 2 provider manual or visit the Medi-Cal website ([www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)).

### NOTE

ACFs and envelopes are provided free of charge to all providers submitting 837 v.5010 electronic transactions.

DO NOT STAPLE  
IN BAR AREA



**MEDI-CAL CLAIM ATTACHMENT CONTROL FORM**  
STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

**ATTACHMENT CONTROL NUMBER** 999999999999

DO NOT  
WRITE IN  
THIS SPACE

PROVIDER NUMBER :

[Redacted box for Provider Number]

(REQUIRED)

PROVIDER NAME :

PROVIDER ADDRESS :

**VOID**

(PLEASE PRINT IN BLACK OR BLUE INK TO COMPLETE THIS FORM)

FOR F.I. USE ONLY

1 2 3 4

RETURN THIS FORM WITH ATTACHMENTS TO:

**FISCAL INTERMEDIARY**  
P.O. BOX 526022  
SACRAMENTO, CA 95852

PROVIDER SIGNATURE

DATE

X \_\_\_\_\_

USE THIS FORM AS A COVER SHEET FOR PAPER DOCUMENTATION TO SUPPORT THE ELECTRONICALLY SUBMITTED CLAIM.  
FOR FURTHER INFORMATION REGARDING USE OF THE ATTACHMENT CONTROL FORM SEE THE PROVIDER MANUAL.

FORM NUMBER ACF-001



Xerox State Healthcare, LLC  
820 Stillwater Road  
West Sacramento, CA 95605

Date:

**ATTACHMENT CONTROL FORM REJECT LETTER**

This letter is to inform you that the coversheet or Attachment Control Form (ACF) you submitted does not meet Medi-Cal standards. It has been rejected for the following reason(s):

\_\_\_\_\_ **Invalid ACF**  
(Only original ACFs provided by California Department of Health Services will be accepted)

\_\_\_\_\_ **Missing ACF**  
(Paper attachments submitted without ACF)

\_\_\_\_\_ **Supporting documentation missing**  
(ACF received without paper attachments)

\_\_\_\_\_ **Invalid Attachment Control Number (ACN) on ACF**  
(Pre-imprinted CANNOT be altered or unreadable)

\_\_\_\_\_ **Other:** \_\_\_\_\_

Please resubmit your electronic claim if:

The resubmitted ACF has an Attachment Control Number (ACN) that differs from your original electronic claim form or;

More than 30 days have passed since you originally submitted your electronic claim.

Mail Attachments to - Fiscal Intermediary  
P.O. Box 526022  
Sacramento, CA 95852

If you have any questions regarding this notice or submitting attachments, please call the Telephone Service Center at 1-800-541-5555.

Sincerely,

**ACF Rejection Letter**

# UB-04 Claim Form Completion

## UB-04 Claim Form

The *UB-04* claim form is a national form; therefore, many fields are not required by Medi-Cal. The information presented in this module focuses on the claim form fields that apply to Medi-Cal claims.

1		2		3a PAT. CNTRL. #	4 TYPE OF BILL	
				b. MED. REC. #		
				5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH
8 PATIENT NAME		9 PATIENT ADDRESS				
a		a		b	c	d
b		b		c	d	e

Sample Partial *UB-04* Claim Form

## Field Descriptions: 1 – 4

Box #	Field Name	Instructions
1	Provider Name, Address, ZIP Code	Enter the provider name, hospital and clinic address without a comma between the city and the state, and the nine-digit ZIP code without a hyphen. A telephone number is optional in this field.
3a	Patient Control Number	<i>(Optional Field)</i> Enter the patient's financial record number or account number in this field. A maximum of 20 characters may be used, but only 10 characters will appear on the <i>Resubmission Turnaround Document (RTD)</i> and <i>Remittance Advice Detail (RAD)</i> . <b>NOTE</b> This field helps providers easily identify a recipient on RTDs and RADs.
3b	Medical Record Number	<i>Not Required (for Medi-Cal)</i> Use Box 3a to enter a patient control number.
4	Type Of Bill	<i>Required (for Medi-Cal)</i> Enter the appropriate three-character type of bill code as specified in the <i>National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual</i> . <b>NOTE</b> For subacute services, specify the appropriate Place of Service and use modifier U2 (Outpatient Services). <b>Billing Tip:</b> The type of bill code includes a ____-digit facility type code and a ____-digit claim frequency code.

Answer Key: 4) two, one

### Field Description: 6

Box #	Field Name	Instructions
6	Statement Covers Period (From-Through)	<p><b>Outpatient Claims:</b> <i>Not required</i></p> <p><b>Inpatient Claims:</b> Enter the dates of service for this claim in six-digit MMDDYY (month, day, year) format. The date of discharge should be entered in the <i>Through</i> box, even though this date is not reimbursable (unless the day of discharge is the date of admission).</p> <p><b>NOTE</b></p> <p>For "From-Through" billing instructions, refer to the <i>UB-04 Special Billing Instructions for Inpatient Services</i> section (ub spec ip) in the Part 2 provider manual.</p>

8 PATIENT NAME		a	9 PATIENT ADDRESS		a															
b		b		c	d															
10 BIRTHDATE	11 SEX	12 DATE	ADMISSION			16 DHR	17 STAT	CONDITION CODES					29 ACCT STATE	30						
			13 HR	14 TYPE	15 SRC			18	19	20	21	22	23	24	25	26	27	28		

Sample Partial UB-04 Claim Form

### Field Descriptions: 8B – 10

Box #	Field Name	Instructions
8b	Patient Name	<p>Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases.</p> <p><b>Newborn Infant:</b> When submitting a claim for a newborn infant using the mother's ID number, enter the infant's name in Box 8b. If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (example: JONES BABY GIRL). If billing for newborn infants from a multiple birth, each newborn must also be designated by a number or a letter (for example; JONES BABY GIRL TWIN A). Enter the mother's name in the <i>Insured's Name</i> field (Box 58) and enter "03" (Child) in the <i>Patient's Relationship to Insured</i> field (Box 59).</p> <p><b>Organ Donors:</b> When submitting a claim for a patient donating an organ to a Medi-Cal recipient, enter the donor's name, date of birth and sex in the appropriate boxes. Enter the Medi-Cal recipient's name in the <i>Insured's Name</i> field (Box 58) and enter "11" (Donor) in the <i>Patient's Relationship to Insured</i> field (Box 59).</p> <p><b>Billing Tip:</b> Claims for newborn infants from a multiple birth must be submitted on the same claim. [True or False]</p>
10	Birth Date	Enter the patient's date of birth, using an eight-digit MMDDYYYY (month, day, year) format (for example, September 16, 1967 = 09161967).

Answer Key: 8b) False

Field Descriptions: 11 – 15

Box #	Field Name	Instructions								
11	Sex	<p>Enter the capital letter “M” for male or “F” for female.</p> <p><b>Billing Tip:</b> When submitting a claim for a newborn infant using the mother’s ID number, enter the infant’s gender in Field 11. [True or False]</p>								
12 – 13	Admission Date and Hour	<p><b>Outpatient Claims:</b> <i>Not required</i></p> <p><b>Inpatient Claims:</b> Enter the date of hospital admission, in six-digit format. Convert the hour of admission to the 24-hour (00-23) format. Do not include the minutes.</p> <p><b>Billing Tip:</b> The admit time of 1:45 p.m. will be entered on the claim as _____.</p>								
14	Admission Type	<p><b>Outpatient Claims:</b> Enter an admit type code of “1” when billing for emergency room-related services (in conjunction with facility type “14” in Box 4). This field is not required by Medi-Cal for any other use.</p> <p><b>Inpatient Claims:</b> Enter the numeric code indicating the necessity for admission.</p> <table border="1"> <thead> <tr> <th>Patient Admission Status</th> <th>Code</th> </tr> </thead> <tbody> <tr> <td>Emergency</td> <td>1</td> </tr> <tr> <td>Elective</td> <td>3</td> </tr> <tr> <td>Newborn</td> <td>4</td> </tr> </tbody> </table> <p><b>NOTE</b> “Newborn” admission code is used only for an infant born outside of the hospital, in conjunction with appropriate revenue code and source of admission code “4.”</p>	Patient Admission Status	Code	Emergency	1	Elective	3	Newborn	4
Patient Admission Status	Code									
Emergency	1									
Elective	3									
Newborn	4									
15	Source of Admission	<p><b>Outpatient Claims:</b> <i>Not required</i></p> <p><b>Inpatient Claims:</b> If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. Enter code “1” or “3” in Box 14 to indicate whether the transfer was an emergency or elective.</p> <table border="1"> <thead> <tr> <th>Transfer Source</th> <th>Code</th> </tr> </thead> <tbody> <tr> <td>Transfer from a hospital</td> <td>4</td> </tr> <tr> <td>Transfer from a Skilled Nursing Facility (SNF)</td> <td>5</td> </tr> <tr> <td>Transfer from another health care facility</td> <td>4</td> </tr> </tbody> </table>	Transfer Source	Code	Transfer from a hospital	4	Transfer from a Skilled Nursing Facility (SNF)	5	Transfer from another health care facility	4
Transfer Source	Code									
Transfer from a hospital	4									
Transfer from a Skilled Nursing Facility (SNF)	5									
Transfer from another health care facility	4									

Answer Key: 11) True; 12 – 13) 13

## Field Descriptions: 16 – 24

Box #	Field Name	Instructions								
16	Discharge Hour	<p><b>Outpatient Claims:</b> <i>Not required</i></p> <p><b>Inpatient Claims:</b> Enter the discharge hour as follows:</p> <ul style="list-style-type: none"> <li>Do not include the minutes</li> <li>Convert discharge hour to 24-hour (00-23) format, e.g. 3:00 p.m. = 15.</li> </ul> <p><b>NOTE</b> If the patient has not been discharged, leave this field blank.</p>								
17	Status	<p><b>Outpatient Claims:</b> Not required</p> <p><b>Inpatient Claims:</b> Enter the numeric code explaining patient status as of the Through date entered in the <i>Statement Covers Period</i> field (Box 6). Refer to billing instructions in the <i>UB-04 Completion: Inpatient Services</i> section (ub comp ip) of the Part 2 provider manual for status codes and explanations.</p> <table border="1"> <thead> <tr> <th>Patient Status</th> <th>Code</th> </tr> </thead> <tbody> <tr> <td>Discharged to home</td> <td>01</td> </tr> <tr> <td>Expired</td> <td>20</td> </tr> <tr> <td>Still a patient</td> <td>30</td> </tr> </tbody> </table>	Patient Status	Code	Discharged to home	01	Expired	20	Still a patient	30
Patient Status	Code									
Discharged to home	01									
Expired	20									
Still a patient	30									
18 – 24	Condition Codes	<p>Condition codes are used to identify conditions related to the patient's bill that may affect payer processing. These codes should be entered from left to right in numeric-alpha sequence starting with the lowest value. For example, if billing for three condition codes, "A1" (services related to Family Planning), "80" (Other Health Coverage) and "82" (Outside Laboratory), enter "80" in Box 18, "82" in Box 19, and "A1" in Box 20.</p> <p><b>Billing Tip:</b> When Condition Code "81" is entered to indicate emergency services are being billed, what must be attached to the claim or entered in the <i>Remarks</i> field?</p> <p>_____</p> <p>_____</p> <p><b>NOTE</b> The Medi-Cal claims processing system recognizes condition codes entered in Boxes 18 – 24 only.</p>								

31 CODE	OCURRENCE DATE	32 CODE	OCURRENCE DATE	33 CODE	OCURRENCE DATE	34 CODE	OCURRENCE DATE	35 CODE	OCURRENCE SPAN FROM	THROUGH	36 CODE	OCURRENCE SPAN FROM	THROUGH	37
a														b
38								39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT	
								a						
								b						
								c						
								d						

Sample Partial UB-04 Claim Form

### Field Descriptions: 31 – 34A – B

Box #	Field Name	Instructions																																				
31 – 34 a – b	Occurrence Codes and Dates	<p>Occurrence codes and dates are used to identify significant events related to a claim that may affect payer processing. Occurrence codes and dates should be entered from left to right, top to bottom in numeric-alpha order starting with the lowest value.</p> <p><u>Example:</u> If billing for two occurrence codes “24” (accepted by another payer) and “05” (accident/no medical or liability coverage), enter “05” in Box 31a and “24” in Box 32a.</p> <table border="1"> <tr> <td>31 CODE</td> <td>OCURRENCE DATE</td> <td>32 CODE</td> <td>OCURRENCE DATE</td> <td>33 CODE</td> <td>OCURRENCE DATE</td> <td>34 CODE</td> <td>OCURRENCE DATE</td> </tr> <tr> <td>a</td> <td>05</td> <td>061014</td> <td>24</td> <td>061114</td> <td></td> <td></td> <td></td> </tr> <tr> <td>b</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> <p>Although the Medi-Cal claims processing system will only recognize applicable Medi-Cal codes, providers can include codes and dates billed to other payers in Boxes 31 – 34. <u>The claims processing system will ignore all codes not applicable to Medi-Cal.</u> Use these codes if the accident or injury was non-employment related:</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>Accident/medical coverage</td> </tr> <tr> <td>02</td> <td>No fault insurance involved – including auto accident/other</td> </tr> <tr> <td>03</td> <td>Accident/tort liability</td> </tr> <tr> <td>05</td> <td>Accident/no medical or liability coverage</td> </tr> <tr> <td>06</td> <td>Crime victim</td> </tr> </tbody> </table> <p>Enter the accident/injury date in corresponding box (6-digit format MMDDYY).</p> <p><b>NOTE</b> Enter code “04” (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related. Enter accident/injury date in the corresponding box.</p> <p><b>Outpatient Claims:</b> Discharge date is not applicable.</p> <p><b>Inpatient Claims:</b> Discharge Date: Enter occurrence code “42” and the date of hospital discharge (in six-digit format) when the date of discharge is different than the “Through” date in Box 6.</p>	31 CODE	OCURRENCE DATE	32 CODE	OCURRENCE DATE	33 CODE	OCURRENCE DATE	34 CODE	OCURRENCE DATE	a	05	061014	24	061114				b								Code	Description	01	Accident/medical coverage	02	No fault insurance involved – including auto accident/other	03	Accident/tort liability	05	Accident/no medical or liability coverage	06	Crime victim
31 CODE	OCURRENCE DATE	32 CODE	OCURRENCE DATE	33 CODE	OCURRENCE DATE	34 CODE	OCURRENCE DATE																															
a	05	061014	24	061114																																		
b																																						
Code	Description																																					
01	Accident/medical coverage																																					
02	No fault insurance involved – including auto accident/other																																					
03	Accident/tort liability																																					
05	Accident/no medical or liability coverage																																					
06	Crime victim																																					

## Field Descriptions: 37A

Box #	Field Name	Instructions
37a	Unlabeled (use for delay reason codes)	<p>If there is an exception to the six-month billing limit, enter one of the delay reason codes in Box 37a and include the required documentation.</p> <p><b>NOTE</b> Documentation justifying the delay reason must be attached to the claim to receive full payment.</p> <p><b>Billing Tip:</b> Providers billing with delay reason "11" without an attachment will either receive reimbursement at a _____ or _____.</p> <p><b>For hospitals that are not reimbursed according to the diagnosis-related groups (DRG) model:</b> Providers must use claim frequency code "5" in the <i>Type of Bill</i> field (Box 4) of the claim when adding a new ancillary code to a previous stay, if the original stay was already billed.</p>

Answer Key: 37a) reduced rate; claim denial

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	23	5000	30	10000		
b						
c						
d						

Sample Partial UB-04 Claim Form

Field Descriptions: 39 – 41A – D

Box #	Field Name	Instructions
39 – 41 a – d	Value Codes and Amounts	<p>Enter value codes and amounts from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. Do not enter a decimal point (.), dollar sign (\$), positive (+) or negative (-) sign. Enter full dollar amount and cents, even if the amount is even.</p> <p>Value codes and amounts are used to relate amounts to data elements necessary to process the claim. Although the Medi-Cal claims processing system only recognizes code “23,” providers may include codes and dates billed to other payers in Boxes 39 – 41. <u>The claims processing system ignores all codes not applicable to Medi-Cal.</u></p> <p>Example: If billing for two value codes “30” (accepted by another payer) and “23” (accepted by Medi-Cal, Share of Cost [SOC]), enter “23” in Box 39a and “30” in Box 40a. If the SOC collected/obligated is \$50, enter 5000 not 50.</p> <p><b>Billing Tip:</b> Value code information is required for Medicare/Medi-Cal crossover claims.</p>

NOTES

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16 UB-04 Claim Form

42 REV. CD	43 DESCRIPTION	44 HCPCS /RATE /HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
	PAGE OF	CREATION DATE		TOTALS			23

Sample Partial UB-04 Claim Form

Field Descriptions: 42 – 43

Box #	Field Name	Instructions
42	Revenue Code	<p><b>Outpatient Claims:</b> <i>Not required</i></p> <p><b>Inpatient Claims:</b> Enter the appropriate revenue or ancillary code. Refer to the <i>Revenue Codes for Inpatient Services</i> section (rev cd ip) in the appropriate Part 2 provider manual. Ancillary codes are listed in the <i>Ancillary Codes</i> section (ancil cod) of the Part 2 provider manual.</p> <p><b>Billing Tip:</b> For both outpatient and inpatient claims (single-page claims), enter code "001" in Box 42, line 23 to designate the total charge line. Enter the total amount in _____, line 23.</p>
43	Description	<p><b>Outpatient Claims:</b> <i>(Optional)</i> Information entered into this field will help separate and identify the descriptions of each service.</p> <p><b>Inpatient Claims:</b> Enter the description of the revenue or ancillary code listed in the <i>Revenue Code</i> field (Box 42).</p> <p><b>NOTE</b> If there are multiple pages of the claim, enter page numbers on line 23.</p> <p><b>Billing Tip:</b> For outpatient claims, the description must identify the particular service code indicated in <i>HCPCS/Rate</i> field (Box 44). For more information, refer to the CPT-4 code book.</p>

Answer Key: 42) Box 47

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPSP CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
PAGE ____ OF ____		CREATION DATE		TOTALS			
50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ADJ. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
						57 OTHER	
						PRV. ID	

Sample Partial UB-04 Claim Form

Field Descriptions: 44 – 45

Box #	Field Name	Instructions																														
44	HCPCS/ Rate	<p><b>Outpatient Claims:</b> Enter the applicable procedure code and modifier. Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately.</p> <p>Attach reports to the claim for “By Report” codes, complicated procedures (modifier 22) and unlisted services. Reports are not required for routine procedures. Non-payable CPT-4 codes are listed in the <i>TAR &amp; Non-Benefit List: Codes (10000 – 99999)</i> sections in the appropriate Part 2 manual.</p> <p>All modifiers must be billed immediately following the HCPCS code in the <i>HCPCS/Rate</i> field (Box 44) with no spaces. Up to four modifiers may be entered on the outpatient <i>UB-04</i> claim form.</p> <p><b>Inpatient Claims:</b> <i>Not required</i></p> <table border="1"> <thead> <tr> <th>42 REV. CD.</th> <th>43 DESCRIPTION</th> <th>44 HCPCS / RATE / HPSP CODE</th> <th>45 SERV. DATE</th> <th>46 SERV. UNITS</th> <th>47 TOTAL CHARGES</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>EMERGENCY ROOM USE</td> <td>Z7501TC90AB21</td> <td>060214</td> <td>2</td> <td>230000</td> </tr> <tr> <td>2</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPSP CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	1	EMERGENCY ROOM USE	Z7501TC90AB21	060214	2	230000	2						3						4					
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HPSP CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES																											
1	EMERGENCY ROOM USE	Z7501TC90AB21	060214	2	230000																											
2																																
3																																
4																																
45	Service Date	<p><b>Outpatient Claims:</b> Enter the date the service was rendered in six-digit format.</p> <p><b>Inpatient Claims:</b> <i>Not required</i></p> <p><b>Billing Tip:</b> For “From-Through” billing instructions, see the <i>UB-04 Special Billing Instructions for Outpatient Services</i> section (ub spec op).</p>																														

## Field Descriptions: 46 – 50A – C

Box #	Field Name	Instructions
46	Service Units	<p><b>Outpatient Claims:</b> Enter the actual number of times a single procedure or item was provided for the date of service. If billing for more than 99, divide the units on two or more lines.</p> <p><b>Inpatient Claims:</b> Enter the number of days of care by revenue code. Units of service are not required for ancillary services. If billing for more than 99 units, divide the units between two or more lines.</p> <p><b>Billing Tip:</b> Although <i>Service Units</i> is a seven-digit field, Medi-Cal only allows two digits.</p>
47	Total Charges	<p>In full dollar amount, enter the usual and customary fee for the service billed. Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents, even if the amt. is even (e.g., if billing for \$100, enter "10000" not "100").</p> <p>Enter the total charge for all services on the last line or on line 23. Enter "001" in <i>Revenue Code</i> field (Box 42, line 23) to indicate this is the total charge line.</p> <p><b>NOTE</b> Up to 22 lines of data (fields 42 – 49) can be entered. It is acceptable to skip lines.</p> <p><b>Outpatient Claims:</b> If an item is a taxable medical supply, include the applicable state and county sales tax. To delete a line, mark with a thin line through the entire detail line (Boxes 42-49), using a _____ or _____ ballpoint pen.</p>
50a – c	Payer Name	<p><b>Outpatient Claims:</b> Enter "O/P MEDI-CAL" to indicate outpatient claim and payer.</p> <p><b>Inpatient Claims:</b> Enter "I/P MEDI-CAL" to indicate inpatient claim and payer.</p> <p><b>NOTE</b> If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing Medi-Cal.</p> <p><b>Billing Tip:</b> When completing Boxes 50 – 65 (excluding Box 56) enter all information related to the payer on the same line (for example, Line A, B or C) in order of payment (Line A: other insurance, Line B: Medicare, Line C: Medi-Cal). Do not enter information on Lines A and B for other insurance (or Medicare) if payment was denied by these carriers. If Medi-Cal is the only payer billed, all information in Boxes 50 – 65 (excluding Box 56) should be entered on Line A.</p>

Field Descriptions: 54 – 57A – C

Box #	Field Name	Instructions
54a – c	Prior Payments (Other Coverage)	<p>Leave blank if not applicable.</p> <p>Enter the full dollar amount of payment received from OHC, on line A or B that corresponds with OHC in the <i>Payer</i> field (Box 50). Do not enter a decimal point (.), dollar sign (\$), plus (+) or minus (-) sign.</p> <p><b>NOTE</b> For instructions about completing this field for Medicare/Medi-Cal recipients, refer to the <i>Medicare/Medi-Cal Crossover Claims: UB-04</i> section (medi cr ub) in the provider manual.</p>
55a – c	Estimated Amt. Due	<p>In full dollar amount, enter the difference between “Total Charges” (Box 47, line 23) and any deductions. Do not enter a decimal point (.) or dollar sign (\$).</p> <p>Example: Patient’s SOC <i>Value Codes Amount</i> and/or OHC <i>Prior Payments</i>.</p>
56	NPI	<p>Enter the appropriate 10-digit National Provider Identifier (NPI) number.</p>
57a – c	Other Provider ID	<p>Used by atypical providers only. Outpatient and Inpatient Claims: Enter the Medi-Cal provider number, corresponding to the information on lines A, B or C.</p> <p><b>NOTE</b> Required when the NPI is not used in Box 56 and an identification number other than the NPI is necessary for the receiver to identify the provider.</p>

	58 INSURED'S NAME	59 PREL	60 INSURED'S UNIQUE ID
A			
B			
C			

Sample Partial *UB-04* Claim Form

Field Descriptions: 58 – 60A – C

Box #	Field Name	Instructions
58a – c	Insured's Name	<p>If billing for an infant using the mother's ID or for an organ donor, enter the Medi-Cal recipient's name and the patient's relationship to the Medi-Cal recipient in the <i>Patient's Relationship to Insured</i> field (Box 59).</p> <p><b>NOTE</b> This field is not required by Medi-Cal except under these circumstances.</p>
59a – c	Patient's Relationship to Insured	<p>If billing for an infant using the mother's ID or for an organ donor, enter the code indicating the patient's relationship to the Medi-Cal recipient (for example, "03" [CHILD] or "11" [DONOR]).</p> <p><b>NOTE</b> This field is not required by Medi-Cal except under these circumstances.</p>
60a – c	Insured's Unique ID	<p>Enter the recipient's 14-digit ID number as it appears on the Benefits Identification Card (BIC) or paper Medi-Cal card.</p> <p>Recipients often have more than one insurance policy. In this case, it is necessary to determine which policy is primary and which is secondary. This process, called coordination of benefits, prevents the duplication of payments. Medi-Cal is the payer of last resort. If the recipient has other health coverage (OHC) or Medicare, it must be billed before Medi-Cal is billed as a secondary payer. Providers should follow the OHC directives when submitting insurance claims and when submitting claims to commercial insurance plans.</p> <p><b>NOTE</b> Medi-Cal does not accept Health Insurance Claim (HIC) numbers.</p> <p><b>Billing Tip:</b> Verify that the recipient is eligible for the services rendered by using the Point of Service (POS) network.</p>

63 TREATMENT AUTHORIZATION CODES											64 DOCUMENT CONTROL NUMBER				65 EMPLOYER NAME							
A											A				A							
B											B				B							
C											C				C							
66 ICD											67 A B C D E F G H				68							
69 ADMIT DX											70 PATIENT REASON DX				71 PPS CODE				72 EGI			
74 PRINCIPAL PROCEDURE CODE											a OTHER PROCEDURE CODE				b OTHER PROCEDURE CODE				75			
c OTHER PROCEDURE CODE											d OTHER PROCEDURE CODE				e OTHER PROCEDURE CODE				76 ATTENDING NPI			
																			QUAL			
																			LAST			
																			FIRST			
																			77 OPERATING NPI			
																			QUAL			
																			LAST			
																			FIRST			

Sample Partial UB-04 Claim Form

Field Descriptions: 63 – 66

Box #	Field Name	Instructions
63A – C	Treatment Authorization Codes	<p>For services requiring a <i>Treatment Authorization Request</i> (TAR), enter the 11-digit TAR Control Number (TCN). It is not necessary to attach a copy of the Adjudication Response (AR). Recipient information on the claim must match TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TCN can cover services billed on a claim.</p> <p><b>Inpatient Claims:</b> Inpatient claims must be submitted with a TCN, even if an Extension TAR was issued for the same stay. (Enter the Extension TCN in the <i>Remarks</i> field [Box 80].)</p> <p><b>Billing Tip:</b> TAR and non-TAR procedures may be combined on the same claim. [True or False] The EVC number may also be entered in field 63 for documentation of recipient eligibility. [True or False].</p>
66	ICD Indicator	<p>Claims with a diagnosis code in Box 67 must include the ICD indicator "0" for ICD-10-CM diagnosis codes, effective October 1, 2015.</p>

Answer Key: 63A-C) False, False

## Field Descriptions: 67 – 74

Box #	Field Name	Instructions
67	Unlabeled (Primary Diagnosis Code)	<p>ICD-10-CM diagnosis codes have replaced ICD-9-CM, effective October 1, 2015. Include all letters and numbers of the ICD-10-CM diagnosis code to the highest level of specificity (when possible). Do not include a decimal point.</p> <p>The Present on Admission (POA) condition is a condition present at the time the order for inpatient admission occurred. Hospitals must enter a POA indicator (unless exempt) in the shaded portion of boxes 67 and 67A, to the right of the diagnosis field, to indicate when the condition occurred, if known. When the condition is present, use "Y" for yes. When the indicator is "N" for no, it means that the condition was acquired while the patient was in the hospital.</p>
67A	Unlabeled (Secondary Diagnosis Code)	If applicable, enter all letters and/or numbers of the secondary ICD-10-CM diagnosis code to the highest level of specificity (when possible). Do not include a decimal point.
74	Principle Procedure Code and Date	<p><b>Outpatient Claims:</b> Not required</p> <p><b>Inpatient Claims:</b> Enter the appropriate ICD-10-PCS code identifying the primary medical or surgical procedure. Enter the ICD-10-PCS code, without periods or spaces between the numbers. In six-digit format, enter the date the surgery or delivery was performed.</p> <p><b>Billing Tip:</b> Inpatient providers must enter ICD-10-PCS code in this field (not CPT-4/HCPSC surgical procedure code).</p>

### Field Description: 74A – E

Box #	Field Name	Instructions
74a – e	Other Procedure Codes and Dates	<p><b>Outpatient Claims:</b> <i>Not required</i></p> <p><b>Inpatient Claims:</b> Enter the appropriate ICD-10-PCS code, identifying the secondary medical or surgical procedure, without period or spaces between the numbers.</p> <p><b>NOTE</b> For OB vaginal or cesarean delivery and transplants, enter a suitable ICD-10-PCS code in either Box 74 or 74 a – e.</p>

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

Sample Partial *UB-04* Claim Form

### Field Description: 76

Box #	Field Name	Instructions
76	Attending	<p><b>Outpatient Claims:</b> Enter the referring or prescribing physician's NPI in the first box.</p> <p><b>Billing Tip:</b> For atypical referring or prescribing physicians, enter the Medicaid Identifier "1D" in the <i>Qual/ID</i> box and enter the Medi-Cal provider number next to it.</p> <p><b>Inpatient Claims:</b> Enter the attending physician's NPI in the first box. Do not enter a group number. The attending physician's name is not required.</p> <p><b>Billing Tip:</b> For inpatient claims, do not enter the operating or admitting physician NPI in this field.</p>

## Field Descriptions: 77 – 78

Box #	Field Name	Instructions
77	Operating	<p><b>Outpatient Claims:</b> Enter the rendering physician's NPI in the first box.</p> <p><b>Billing Tip:</b> For atypical rendering physicians, enter the Medicaid Identifier "1D" in the <i>Qual ID</i> box and the Medi-Cal Provider number next to it. Do not use a group provider number.</p> <p><b>Inpatient Claims:</b> Enter the operating physician's NPI in the first box. Do not enter a group provider number. The operating physician's name is not required.</p>
78	Other	<p><b>Outpatient Claims:</b> <i>Not required</i></p> <p><b>Inpatient Claims:</b> Enter the admitting physician's NPI in the first box. Do not enter a group provider number. The admitting physician's name is not required.</p>

80 REMARKS	81CC a	
	b	
	c	
	d	

Sample Partial UB-04 Claim Form

Field Description: 80

Box #	Field Name	Instructions
80	Remarks	<p>Use this area for procedures that require additional information, justification or an <i>Emergency Certification Statement</i>. This statement must be signed and dated by the provider and must be supported by a physician, podiatrist or dentist's statement describing the nature of the emergency, including relevant clinical information about the patient's condition. A mere statement that an emergency existed is not sufficient. If the <i>Emergency Certification Statement</i> will not fit in this area, attach the statement to the claim.</p> <p><b>Billing Tips:</b> If additional information cannot be completely entered in this field, attach the additional information to the claim on single-sided 8½ by 11-inch white paper.</p> <ul style="list-style-type: none"> <li>To fit necessary information in the field, the font size may be reduced in the <i>Remarks</i> field (Box 80) and terminology may be abbreviated. [True or False]</li> <li>The POS printout or Internet eligibility response, with the EVC number, must always be attached to the claim. [True or False]</li> </ul>

Answer Key: 80) False, False

# Learning Activities

## Learning Activity 1: Common Claim Completion Errors

### Brainteaser

What is wrong with this claim?

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555		2		3 PAT. CNTL.# 31 MED. REC.#		4 TYPE OF BILL 721	
8 PATIENT NAME a OTT, MARY		9 PATIENT ADDRESS a					
10 BIRTHDATE 08241980		11 SEX F		12 DATE		13 ADMISSION 13 HR. 14 TYPE 15 SRC 16 DHR	
17 STAT YO		18 19 20 21					
31 OCCURRENCE CODE		32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE	
35 OCCURRENCE SPAN FROM		36 OCCURRENCE SPAN THROUGH		37		38	
39 VALUE CODES CODE		40 VALUE CODES AMOUNT		41 VALUE CODES CODE		42 VALUE CODES AMOUNT	
43 DESCRIPTION Maintenance Dialysis With Lab 06/4,8,12,15,19,22,26,29		44 HCPCS / RATE / HPPS CODE		45 SERV. DATE 060116 062916		46 SERV. UNITS 9	
47 TOTAL CHARGES \$1104.00		48 NON-COVERED CHARGES		49		50	
001 PAGE OF		CREATION DATE		TOTALS		110400	
50 PAYER NAME O/P MEDICAL		51 HEALTH PLAN ID		52 REL. INFO.		53 PRIOR PAYMENTS	
54 EST. AMOUNT DUE		55 NPI 0123456789		56 OTHER PAYER ID		57	
58 INSURED'S NAME		59 PREL. 60 INSURED'S UNIQUE ID 90000000A		61 GROUP NAME		62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		66	
67 N039		68		69 ADMIT DX 9		70 PATIENT REASON DX	
71 HPPS CODE		72 EQ		73		74 PRINCIPAL PROCEDURE DATE	
75 OTHER PROCEDURE DATE		76 OTHER PROCEDURE DATE		77 ATTENDING NPI 2345678901		78 QUAL	
79 OTHER PROCEDURE DATE		80 OTHER PROCEDURE DATE		79 OPERATING NPI 0123456789		80 QUAL	
81 REMARKS		81 CC		82 LAST		83 FIRST	
84		85		86		87	
88		89		90		91	
92		93		94		95	

## Learning Activity 1: Answer Key

Box #	Current Data Entries	Correct Entries
1	95823	The nine-digit ZIP code is required.
4	72	The three-digit type of bill code is required.
8	Ott, Mary	The name must be in all capital letters.
44	(blank)	The procedure code must be listed.
46 (Line 1)	9	The number of items must equal the number of "from-through" dates listed.
47 (Line 2)	\$1104.00	Do not enter a decimal point (.) or dollar sign (\$).
55 (Line A)	(blank)	An estimated amount due must be listed.
60 (Line A)	90000000A	A 14-digit ID number must be listed.
66	9	An ICD indicator of "0" must be listed for claims received after October 1, 2015, for the new ICD-10 classification system.

### NOTES

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## Learning Activity 2: Complete It, Submit It, Get Paid

### Outpatient Claim Scenario

The following procedures were performed on January 21, 2016 in an outpatient hospital setting.

#### Patient Information

Patient Name:	Casey Neadsit
Birth Date:	August 24, 2012
Medi-Cal ID Number:	90000000A95001

#### Procedure Information

- Primary Procedure: The plastic repair of cleft lip/nasal deformity, primary bilateral, one stage procedure
- Secondary Procedure: The tympanostomy (requiring insertion of the ventilating tube), also bilateral
- Location of Services Performed: Uptown Medical Center, 140 Second Street, Anytown, CA 95823-5555
- ICD Indicator must reflect a "0" for ICD-10
- Diagnosis Codes: Q378 (primary) and Q179 (secondary) Diagnosis Codes

#### Billing Information

- Primary Procedure: The repair of the cleft/lip/nasal deformity (primary procedure) will be billed using CPT-4 code 40701 with modifier AG (primary surgeon). As the primary surgery, modifier 50 is not necessary with this code. The usual and customary charge is \$4,210.00.
- Multiple Procedure: The tympanostomy will be billed using code 69436 with modifier 51 (multiple procedures). The usual and customary charge is \$600.00.
- Bilateral Procedure: The tympanostomy will be billed a second time, with modifier 50 (bilateral procedure) to signify the additional time required, at the usual and customary charge of \$600.00.
- Billing Hospital (Uptown Medical Center):
  - NPI Number: 0123456789
  - Facility Code: 13 (hospital – outpatient)
  - Claim Sequence: 1 (This is the first and only claim for procedures on 1/21/16.)
- Physician Information:
  - Referring Physician NPI#: 1234567890
  - Rendering Physician NPI#: 2345678901

#### NOTE

When entering data on claims always remember to remove dollar signs (\$) and decimal points (.). In addition, remove hyphens (-) from ZIP codes.



## Learning Activity 3: Complete It, Submit It, Get Paid

### Inpatient Claim Scenario

The following procedures were performed on January 7, 2016 at 7:30 p.m. in a hospital setting.

#### Patient Information

Patient Name: Penny Sillen  
 Birth Date: November 24, 2010  
 Medi-Cal ID Number: 90000000A95001

#### Procedure Information

- Primary Procedure: A young girl was admitted to the emergency room of the hospital, where she was treated for a broken tibia and fibula. After surgery, she entered the recovery room and was later admitted to the pediatric ward. The hospital release date was January 10, 2016 at 11:20 a.m.

#### NOTE

A TAR was submitted retroactively and approved with TCN 01234567890.

- Location Of Services Performed: Uptown Medical Center, 140 Second Street, Anytown, CA 95823-5555

#### Billing Information

- Primary Procedure: The repair of a broken tibia and fibula. Charges are listed below:

Services Provided	Revenue Code	Ancillary Code	Charges
Room and board	123	(na)	\$1,140.00
General pharmacy	(na)	250	\$ 111.00
Sterile surgical supplies	(na)	272	\$ 162.00
General laboratory	(na)	300	\$ 50.00
Diagnostic radiology, general	(na)	320	\$ 880.00
Operating room services, general	(na)	360	\$ 640.00
Anesthesia, general	(na)	370	\$ 251.00
Respiratory services, general	(na)	410	\$ 5.00
Physical therapy, general	(na)	420	\$ 390.00
Emergency room, general	(na)	450	\$ 50.00
Recovery room, general	(na)	710	\$ 102.00
TOTAL:			\$3,781.00

- Billing Hospital (Uptown Medical Center):
  - NPI Number: 0123456789
  - Facility Code: 11
  - Claim Sequence: 1 (This is the first and only claim to be submitted.)
- Physician Information :
  - Admitting Physician's NPI#: 3456789012
  - Attending Physician's NPI#: 1234567890
  - Operating Physician's NPI#: 2345678901

#### NOTE

When entering data on claims always remember to remove dollar signs (\$) and decimal points (.). In addition, remove hyphens (-) from ZIP codes.





# Claims Follow-Up

## Introduction

### Purpose

The purpose of this module is to provide an overview of the options available to providers when following up on claims that have been submitted for payment. Timeliness and claim submission guidelines for follow-up forms will also be discussed.

### Module Objectives

- Review timeliness standards
- Identify delay reason codes
- Understand *Remittance Advice Details* (RAD)
- Discuss the *Resubmission Turnaround Document* (RTD)
- Explain claim follow-up options for the *Claims Inquiry Form* (CIF), the *Appeal* form (90-1) and the Correspondence Specialist Unit (CSU)

### Resource Information

#### **Medi-Cal Subscription Service (MCSS)**

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at ([www.medi-cal.ca.gov/mcss](http://www.medi-cal.ca.gov/mcss)).

#### **References**

The following reference materials provide Medi-Cal claim information.

#### **Provider Manual References**

##### Part 1

*Claim Submission and Timeliness Overview* (claim sub)

## 2 Claims Follow-Up

### Part 2

*Appeal Form Completion* (appeal form)

*CIF Completion* (cif co)

*CIF Submission and Timeliness Instructions* (cif sub)

*CMS-1500 Completion* (cms comp)

*CMS-1500 Submission and Timeliness* (cms sub)

*Remittance Advice Details (RAD)* (remit adv)

*Resubmission Turnaround Document (RTD) Completion* (resub comp)

*UB-04 Completion: Outpatient Services* (ub comp ob)

*UB-04 Submission and Timeliness* (ub sub)

### Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

### Resource Tools

Medi-Cal Website	Telephone Service Center (TSC)	Regional Representatives
<a href="http://www.medi-cal.ca.gov">www.medi-cal.ca.gov</a>	1-800-541-5555	Call TSC and ask for a Regional Representative to visit your office

## Claim Follow-Up Description

After a claim has been submitted for reimbursement, it must be received within a specified time frame to process and adjudicate the claim appropriately for payment or denial. The time frames are specific and need to be adhered to so that providers can receive timely reimbursement. Claims that have been improperly completed will be denied and providers will be notified by mail.

## Claim Reimbursement Guidelines

### Claim Submission Timeliness Requirements

Original Medi-Cal or California Children's Services (CCS) claims must be received by the Fiscal Intermediary (FI) within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit. The following chart depicts the reimbursement rate for Medi-Cal claims.



## Reimbursement Policies

### Full Reimbursement Policy

Providers who submit claims within the six-month billing limit are eligible to receive 100 percent of the Medi-Cal maximum allowable payment for services rendered.

The chart below provides the last date that a claim can be filed to meet six-month submission deadlines for full reimbursement.

Reimbursement Deadlines	
Date of Service (If DOS falls in this month)	Claim Process Date (Process no later than the last day of this month)
January	July
February	August
March	September
April	October
May	November
June	December
July	January
August	February
September	March
October	April
November	May
December	June

### Partial Reimbursement Policy

Claims submitted after the six-month billing limit and received by the Department of Health Care Services (DHCS) Fiscal Intermediary (FI) during the seventh through twelfth months after the month the service was rendered (without a valid reason) will be reimbursed at a reduced rate according to the date the claim was received.

Partial reimbursement rates are paid as follows:

Claims Received	Reimbursement Rate
During 7 – 9 month	75% of the payable amount
During 10 – 12 month	50% of the payable amount
After 12 months	0% (denied)

### Full Reimbursement Exceptions

Claims that are submitted more than six months after the month the service was rendered are eligible for reimbursement at 100 percent of the Medi-Cal maximum allowable payment, as long as the provider has a valid reason for late submission and uses a corresponding delay reason code, listed below.

### Delay Reason Codes – Late Claims

Claims can be billed beyond the six-month billing limit if a delay reason code is used. The delay reason code indicates that the claim form is being submitted after the six-month billing limit. Although a delay reason code designates approved reasons for late claim submission, these exceptions also have time limits.

Delay Reason Code	Description
1	Proof of Eligibility (POE) unknown or unavailable
3	TAR approval delays
4	Delay by DHCS in certifying providers
5	Delay in supplying billing forms
6	Delay in delivery of custom-made eye appliances
7	Third party processing delay
10	Administrative delay in prior approval process
11	Other (e.g. theft); attach documentation justifying the delay reason
15	Natural disaster

**NOTE**

To receive full payment, providers must attach documentation justifying the delay reason. Providers billing with delay reason code “11” without an attachment will be denied or reimbursed at a reduced rate.

## Partial Reimbursement Exceptions

### Claims Over One Year

Occasionally, a claim may be delayed more than one year past the date of service. The following is a list of possible scenarios that could result in a claim being submitted beyond one year:

- Third party decisions or appeals
- Determination of Medi-Cal eligibility
- *Treatment Authorization Request* (TAR) approval delay

Providers may still be eligible to receive 100 percent reimbursement of the Medi-Cal maximum allowable rate. Claims submitted more than 12 months after the month of service must use delay reason code 10. These claims must be billed hard copy and with appropriate attachments. Providers can send late claims to the FI at the following address:

Xerox State Healthcare, LLC  
 Over-One-Year Claims Unit  
 P.O. Box 13029  
 Sacramento, CA 95813-4029

Claims submitted to the Over-One-Year Claims Unit must include a copy of the recipient's proof of eligibility and may have additional documentation requirements as listed in the *UB-04 Submission and Timeliness Instructions* and *CMS-1500 Submission and Timeliness Instructions* sections (ub sub and cms sub) in the appropriate Part 2 Medi-Cal provider manual.

#### NOTE

- Claims and attachments more than a year old may not be submitted electronically.
- Claims more than a year old will not receive an acknowledgement or response letter.
- Providers will receive a RAD message indicating the status of their claim.



# Claim Follow-Up Process

Medi-Cal claims received by the FI may not process through the California Medicaid Management Information System (CA-MMIS) as providers anticipate; sometimes claims are suspended or denied.

There are a number of reasons why claims do not process correctly. Some examples include:

- Minor information is omitted from the claim.
- Recipient information is incorrect.
- The claim is suspended due to internal research.

CA-MMIS looks at claims critically in a series of edits and audits. After these edits and audits are complete, the claim is adjudicated or suspended. Depending on the reason the claim was suspended or denied, the provider can take one of the following actions:

If Claim was:	Provider Follow-up Options
Suspended	Return a <i>Resubmission Turnaround Document</i> (RTD).
	Contact the Correspondence Specialist Unit (CSU).
	Rebill the claim.
Denied	Submit a <i>Claims Inquiry Form</i> (CIF).
	Submit an <i>Appeal</i> form.
	Contact the Correspondence Specialist Unit (CSU).
	Rebill the claim.

## Financial Reconciliation Statement – Remittance Advice Details (RAD)

### **RAD Description**

The RAD is designed for line-by-line reconciliation of transactions. RADs offer providers a record to help determine which claims are paid, denied or not yet adjudicated. RADs are issued by the State Controller's Office (SCO) and contain reimbursement data of claims being paid relevant to the payment period and a cumulative summary of year-to-date earnings.

If there are no claims being paid, or if a payment is being applied to a negative adjustment or Accounts Receivable (A/R), a *No Payment Advice* will be issued instead of a warrant.

Medi-Cal-only claims appear first, followed by Medicare/Medi-Cal crossover claims in the following sequence: adjustments, approvals, denials, suspensions and A/R transactions.

### **Adjustments**

Previously paid claims may be adjusted if an error in payment occurred. An adjustment may be initiated by the provider, the FI or the State. A CIF is used for processing an adjustment. An adjustment reprocesses a claim with corrected information and appears on the RAD as two lines.

- Line 1 – Shows the new Claim Control Number (CCN) – deducts the original payment.
- Line 2 – Shows the original CCN – reflects the correct payment.

A "void" adjustment appears on the RAD as a single line with a negative (-) amount. A void recovers the original payment without automatically reprocessing the claim. After a void is completed and the claim history is adjusted, providers may submit a new claim.

### **Approvals**

Approved claims are line items passing final adjudication. They may be reimbursed as submitted or at reduced amounts according to Medi-Cal program reimbursement specifications. Reduced payments are noted on the RAD with the corresponding RAD code.

## Denials

Denied claim lines represent claims that are unacceptable for payment due to one of the following conditions:

Claim information cannot be validated by the Fiscal Intermediary

- Billed service is not a program benefit
- Line item fails the edit/audit process
- Provider fails to return an RTD within the 60-day period

### NOTE

A denied message on the RAD is the only record of a claim denial.

## Suspensions

Claims requiring manual review or return of an RTD will temporarily suspend and appear on the RAD with a “suspend” message code. After a suspended claim has been in the claims processing system for more than 30 days, it will appear on the RAD until payment or denial.

### NOTE

Providers should not submit CIFs for claims listed as “Suspends” on the *most recent* RAD because a CIF can only be processed on claims that have already been adjudicated.

## Accounts Receivable Transactions

RADs may also reflect Accounts Receivable (A/R) transactions when necessary either to recover funds from or pay funds to a provider. Claims that appear on the RAD are sorted by recipient name (alphabetical by last name of recipient and date of service). The Accounts Receivable system is used in financial transactions.

- A/R Transaction Types:
  - Recoupment of interim payments
  - Withholds against payments to providers according to State instructions
  - Payments to providers according to State instructions
- Unique Features:
  - A/R transactions are identified in the system by a 10-digit A/R transaction number, such as "1234567890".
  - Amounts can be either positive (+) or negative (-) figures that correspond to the increase or decrease in the amount of the warrant.
  - A/R transaction codes appear at the bottom of the page in the RAD message column and begin with the number "7."

Inquiries about Accounts Receivable transactions should be mailed to the Xerox Cash Control Unit. Inquires must be submitted hard copy and include the A/R number and a copy of the RAD.

Xerox State Healthcare, LLC  
Attn: Cash Control  
P.O. Box 13029  
Sacramento, CA 95813-4029

## Remittance Advice Details Form Example

<b>CA MEDI-CAL</b> <b>REMITTANCE ADVICE</b> <b>DETAILS</b>										TO: ABC PROVIDER 1000 ELM STREET ANYTOWN, CA 95422-6720	
										REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES	
PROVIDER NUMBER	CLAIM TYPE	WARRANT NO		EDS SEQ. NO		DATE		PAGE: 1 of 1 pages			
XXXXXXXXXX	MEDICAL	39248026		20000617		09/01/15					
RECIPIENT NAME	RECIPIENT MEDI-CAL I.D. NO.	CLAIM CONTROL NUMBER	SERVICE DATES		PROCED. CODE MODIFIER	PATIENT ACCOUNT NUMBER	QTY	BILLED AMOUNT	PAYABLE AMOUNT	PAID AMOUNT	RAD CODE
			FROM	TO							
			MM DD YY	MM DD YY							
APPROVES (RECONCILE TO FINANCIAL SUMMARY)											
SMITH DAVID	999999991	5079350917901	060715	060715	XXXXX		0001	20.00	16.22	16.22	0401
		5079350917902	061415	061415	XXXXX		0001	20.00	16.22	16.22	0401
						TOTAL		40.00	32.44	32.44	
JONES JOHN	999999992	5044351314501	050315	050315	XXXXX		0001	30.00	27.03	27.03	0401
		5044351314502	051015	051015	XXXXX		0001	20.00	16.22	16.22	0401
						TOTAL		50.00	43.25		
								90.00	75.69	75.69	AMT PAID
***** TOTALS FOR APPROVES											
DENIES (DO NOT RECONCILE TO FINANCIAL SUMMARY)											
DAVIS MARY	999999993	5011340319001	032715	032715	XXXXX		0001	30.00			0036
						TOTAL NUMBER OF DENIES					
SUSPENDS (DO NOT RECONCILE TO FINANCIAL SUMMARY)											
BROWN JANE	999999994	5034270703001	040515	040515	XXXXX		0001	20.00			0602
BELL JOHN	999999995	5034270712305	040515	040515	XXXXX		0001	20.00			0602
		5034270712306	041215	041215	XXXXX		0001	20.00			0602
						TOTAL		40.00			
JOHNSON M	999999996	5034270712502	042415	042415	XXXXX		0001	20.00			0602
		PAT LIAB	932.00	OTH	COVG	0.00					
						SALES TX	0.00				
						TOTAL NUMBER OF SUSPENDS	0004	80.00			
EXPLANATION OF DENIAL/ADJUSTMENT CODES											
0401	PAYMENT ADJUSTED TO MAXIMUM ALLOWABLE										
0036	RTD WAS EITHER NOT RETURNED OR WAS RETURNED UNCORRECTED; THEREFORE, YOUR CLAIM IS FORMALLY DENIED										
0602	PENDING ADJUDICATION										
OHC CARRIER NAME AND ADDRESS											
NO49	123 NATIONAL LIFE		100 MAIN STREET		ANYTOWN	MN	99999				

**Completed Sample Remittance Advice Details (RAD). Actual size is 8½ x 11 inches.**

**NOTE**

For additional information, refer to the Part 2 provider manual, *Remittance Advice Details (RAD) Examples: Allied Health and Medical Services* section (remit ex am).

## Julian Date Calendar

2016 is a leap year. For non-leap years, subtract one day from the number of days after February 28. Upcoming leap years include 2020 and 2024.

Day Month	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1	1	32	61	92	122	153	183	214	245	275	306	336
2	2	33	62	93	123	154	184	215	246	276	307	337
3	3	34	63	94	124	155	185	216	247	277	308	338
4	4	35	64	95	125	156	186	217	248	278	309	339
5	5	36	65	96	126	157	187	218	249	279	310	340
6	6	37	66	97	127	158	188	219	250	280	311	341
7	7	38	67	98	128	159	189	220	251	281	312	342
8	8	39	68	99	129	160	190	221	252	282	313	343
9	9	40	69	100	130	161	191	222	253	283	314	344
10	10	41	70	101	131	162	192	223	254	284	315	345
11	11	42	71	102	132	163	193	224	255	285	316	346
12	12	43	72	103	133	164	194	225	256	286	317	347
13	13	44	73	104	134	165	195	226	257	287	318	348
14	14	45	74	105	135	166	196	227	258	288	319	349
15	15	46	75	106	136	167	197	228	259	289	320	350
16	16	47	76	107	137	168	198	229	260	290	321	351
17	17	48	77	108	138	169	199	230	261	291	322	352
18	18	49	78	109	139	170	200	231	262	292	323	353
19	19	50	79	110	140	171	201	232	263	293	324	354
20	20	51	80	111	141	172	202	233	264	294	325	355
21	21	52	81	112	142	173	203	234	265	295	326	356
22	22	53	82	113	143	174	204	235	266	296	327	357
23	23	54	83	114	144	175	205	236	267	297	328	358
24	24	55	84	115	145	176	206	237	268	298	329	359
25	25	56	85	116	146	177	207	238	269	299	330	360
26	26	57	86	117	147	178	208	239	270	300	331	361
27	27	58	87	118	148	179	209	240	271	301	332	362
28	28	59	88	119	149	180	210	241	272	302	333	363
29	29	60	89	120	150	181	211	242	273	303	334	364
30	30	---	90	121	151	182	212	243	274	304	335	365
31	31	---	91	---	152	---	213	244	---	305	---	366

### NOTE

The Claim Control Number is used to identify and track Medi-Cal claims as they move through the claims processing system. This number contains the Julian date, which indicates the date a claim was received by the FI and is used to monitor timely submission of a claim.

## Claim Control Numbers

The CCN is used to identify and track Medi-Cal claims as they move through the claims processing system. This number contains the Julian date, which indicates the date a claim was received by the FI, and is used to monitor timely submission of a claim.

**CLAIM CONTROL NUMBER • FOR FI USE ONLY**

80 11 12 34 567 01

<p><b>JULIAN DATE</b> (Date claims received) January 11, 1998 (11th day of 1998)</p>	<p><b>REEL NO.</b></p>	<p><b>BATCH NO.</b></p>	<p><b>CLAIM SEQUENCE NO.</b></p>	<p><b>HEADER/LINE NO. ADJUDICATED</b></p>
--	------------------------	-------------------------	----------------------------------	---

**REEL NUMBERS:**

01-44, 48-49	Original Claim
45-47, 60-65	CMC
69, 71-74	CIF
82-89, 92	Crossover
98,99	Appeals

## Claim Follow-up Forms

### Resubmission Turnaround Document (RTD)

The RTD is used to notify providers when there is questionable or missing information on the claim. The RTD gives providers the opportunity to correct the claim before it is denied. Providers should return Section B (bottom portion) of the RTD to the FI by the date indicated at the top of the RTD.

Providers have two options when they receive an RTD:

- Complete and return Part B (the bottom portion of the RTD).
- Submit a new claim, if timeliness permits.

The RTD should be mailed in a plain business envelope to the FI at the following address:

Xerox State Healthcare, LLC  
P.O. Box 15200  
Sacramento, CA 95851-1200

When the FI receives the RTD, an operator keys in the corrections and the claim continues in the processing cycle.

**RTD Form Example**

RESUBMISSION TURNAROUND DOCUMENT

INSTRUCTIONS: Listed in Section "A" are error(s) found on the original claim. To expedite payment, type the correct information in the numbered Box of Section "B" that corresponds to numbered line in Section "A", sign and date the form, and return Section "B" (bottom portion) to F.I. Please respond promptly as the claim cannot be paid unless your corrections are received by October 31, 2007. See your provider manual for assistance regarding the completion of this form.

INFORMATION BLOCK	SUBMITTED INFORMATION	SERVICE CODE	ERROR CODE	BEG	DOS - PATIENT NAME - COR INFO
1	TAR CONTROL NUMBER A1123456789		0012	07/08/15	Smith, Mike
2					
3					
4					
5					
6					

ERROR DESCRIPTION

0012 - THE NUMBER GIVEN ON THE CLAIM AS THE TAR CONTROL NUMBER IS NOT NUMERIC OR HAS AN INCORRECT NUMBER OF DIGITS

PROVIDER NAME AND ADDRESS

ABC PROVIDER  
123 ANY STREET  
ANYTOWN, CA 95000

PROVIDER NUMBER XXXXXXXXXX		<b>FINAL NOTICE</b>	
DATE	PAGE	OF	
August 30, 2015	1	1	
SERVICE DATE(S) / PROVIDER REFERENCE NO. August 15, 2015			

RETAIN THIS PORTION

PATIENT NAME SMITH, MIKE	MEDI-CAL ID NUMBER 12345678A02009	MEDICAL RECORDS NO. 12345	TOTAL CHARGES \$1575.00	CLAIM CONTROL NUMBER 0170626097022
-----------------------------	--------------------------------------	------------------------------	----------------------------	---------------------------------------

DETACH AND RETURN TO APPROPRIATE F.I.



CORRESPONDENCE REFERENCE NUMBER - F.I. USE ONLY

4

PROVIDER NUMBER  
XXXXXXXXXX

**FINAL NOTICE**

PROVIDER NAME

PATIENT MEDI-CAL ID NO.

PATIENT NAME

F.I. USE ONLY				CORRECT INFORMATION MUST BE ENTERED ON THE SAME LINE AS THE ERROR SHOWN IN SECTION "A"	
CCN	CLAIM TYPE	PAGE OF	PAGES	CORRECT INFORMATION	
0170626097022		1	1	<input type="checkbox"/>	
SUBMITTED INFORMATION	CODE	LINE	FIELD LABEL	<input type="checkbox"/>	
A1123456789	0012	01	012	<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	

This is to certify that the corrected information is true, accurate and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form. DATE

IF SPECIFICALLY REQUESTED, PLACE LABEL IN THE BOX INDICATED BELOW. THIS SPACE MAY ALSO BE USED FOR COMMENTS.

<b>1</b>	<b>2</b>	<b>3</b>
<b>4</b>	<b>5</b>	<b>6</b>

# Claims Inquiry Form (CIF)

The CIF is used to resolve claim payments or denials as identified on the RAD. There are four main reasons to submit a CIF:

- Trace a claim.
- Request reconsideration of a denied claim.
- Adjust an underpayment or overpayment of a claim.
- Request Share of Cost (SOC) reimbursement.

DO NOT STAPLE IN BAR AREA

(1) CORRESPONDENCE REFERENCE NUMBER - FOR F.I. USE ONLY

8  
FASTEN  
HERE

## CLAIMS INQUIRY

SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

READ INSTRUCTIONS ON REVERSE PRIOR TO COMPLETING AND SIGNING THIS FORM. DO NOT TYPE/MARK IN SHADED AREAS.

(2) DOCUMENT NUMBER  
**39377390**

TYPEWRITER ALIGNMENT  
Elite Pica

(3) PROVIDER NAME/ADDRESS  
**ABC PROVIDER  
123 ANY STREET  
ANYTOWN CA 999995555**

(4) PROVIDER NUMBER  
**XYZ123456**

TYPEWRITER ALIGNMENT  
Elite Pica

(5) CLAIM TYPE CHECK ONE BOX ONLY

<input type="checkbox"/> 01 PHARMACY	<input type="checkbox"/> 03 HOSPITAL INFANT	<input checked="" type="checkbox"/> 05 PHYSICIAN ALLIED
<input type="checkbox"/> 02 LTC	<input type="checkbox"/> 04 HOSPITAL OUTPATIENT CLINIC	<input type="checkbox"/> 07 VISION

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

(6) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDICAL ID. NO.	(9) CLAIM CONTROL NO. (TRACER/LEAVE BLANK)	LINE	(10) ATTACHMENT
<input type="checkbox"/> 01	JONES	90000000A95001	72513434534	02	<input checked="" type="checkbox"/> (1) UNDERPAYMENT <input type="checkbox"/> (2) OVERPAYMENT
<input type="checkbox"/> 02	BROWN	90000000A95002	72503878910	01	<input checked="" type="checkbox"/> (1) UNDERPAYMENT <input checked="" type="checkbox"/> (2) OVERPAYMENT
<input type="checkbox"/> 03	SMITH	90000000A95003	72559327654	01	<input checked="" type="checkbox"/> (1) UNDERPAYMENT <input type="checkbox"/> (2) OVERPAYMENT
<input type="checkbox"/> 04					<input type="checkbox"/> (1) UNDERPAYMENT <input type="checkbox"/> (2) OVERPAYMENT

REMARKS: (CORRECTIONS OR ADDITIONAL INFORMATION NECESSARY TO RESUBMIT A DENIED CLAIM, OR REQUEST AN ADJUSTMENT FOR AN UNDERPAYMENT OR AN OVERPAYMENT)

LINE 1: CLAIM DENIED 001 BECAUSE RECIPIENT WAS INELIGIBLE FOR MONTH OF SERVICE. RETROACTIVE ELIGIBILITY INFORMATION RECEIVED AUGUST 3. PLEASE RECONSIDER.

LINE 2: WE BILLED FOR \$5.00 INSTEAD OF \$50.00. SEE CORRECTED CLAIM. PLEASE ADJUST.

LINE 3: CLAIM BILLED IN ERROR. INSURANCE PAID. PLEASE RECOUP PAYMENT OF \$22.00.

1. What went wrong with the claim?

2. What has the biller/provider done to correct the claim?

3. What do you want Medi-Cal/FI to do with the claim?

This is to certify that the information contained above is true, accurate, and complete, and that the provider has read, understood, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

**JANE DOE**

Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on the back of this form.

**9/15/15**

DATE

PROVIDER COPY - RETAIN FOR YOUR FILE 00-1 0007

- **Adjustment** – A claim has been paid at a different amount from the expected Medi-Cal maximum allowable and a provider requests an adjustment for underpayment or overpayment. Adjustment requests for underpayments must be submitted within six months following the date of payment on a RAD. Requests for overpayment adjustments may be submitted any time.
- **Reconsideration** – A claim has been denied and a provider has information that would correct the reason for denial. Requests for reconsideration of denied claims must be submitted within six months following the date of denial on a RAD. However, submitting a new claim within the original six-month billing limit may be a faster process.
- **Trace** – No record of payment or denial of a previously submitted claim exists on the RAD and a provider wants to trace the status of a claim. Tracers may be submitted any time. However, the CIF processing system will only find information from the past 36 months of adjudicated claims. If a tracer is being used to prove timely submission of a claim, it must be received within the same six-month billing limit for claims.
- **Share of Cost (SOC)** – SOC reimbursement requests are considered to be a form of adjustment. *Claims Inquiry Forms* (CIFs) submitted for Share of Cost reimbursement services require unique completion instructions. All SOC inquiries on a CIF must be for SOC reimbursement only.

CIFs should be submitted in a timely manner and mailed in black and white envelopes available from the FI at the following address:

Xerox State Healthcare, LLC  
P.O. Box 15300  
Sacramento, CA 95851-1300

### Claims Inquiry Form Attachments

The following attachments are required for all CIFs as they apply to the claim, except those used as tracers or those requesting SOC reimbursements:

- TAR indicating authorization
- "By Report" documentation
- Completed sterilization *Consent Form* (PM 330)
- *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN)/*National Standard Intermediary Remittance Advice* (Medicare RA)
- *Explanation of Benefits* (EOB) from Other Health Coverage (OHC)
- Drugs and supplies itemization list, manufacturer's invoice or description, including the name of the medication, dosages, strength and unit price
- Supplier's invoice, indicating wholesale price and the item billed
- Manufacturer's name, catalog (model) number and manufacturer's catalog page, showing suggested retail price
- Copy of Point of Service (POS) device printout or Internet eligibility response attached to the claim on an 8<sup>1</sup>/<sub>2</sub> x 11-inch sheet of white paper

#### NOTE

All supporting documentation must be legible.

## Claims Inquiry Acknowledgement

Within 15 days of receipt, the FI acknowledges requests for adjustments and reconsideration of denied claims with a *Claims Inquiry Acknowledgement*. The claim should appear on a RAD within 45 days after the *Claims Inquiry Acknowledgement* is received. The *Claims Inquiry Acknowledgement* serves as proof of timely submission if additional claim follow-up is needed. If the FI does not respond after the initial CIF is filed, providers should file an appeal.

<b>MEDI - CAL</b> FISCAL INTERMEDIARY P.O. BOX 15300 SACRAMENTO, CA 95851-1300		This notice acknowledges receipt to the claims inquiry referenced below. A detailed response to your inquiry will be sent to you as soon as possible. Further communication regarding this claims inquiry should include the correspondence reference and document numbers.						
CA LINE	PATIENT'S NAME OR MEDICAL RECORD #	PATIENT'S MEDI-CAL I.D. NUMBER	CLAIM CONTROL NUMBER	LINE	DATE OF SERVICE	NDIC / UPN OR PROCEDURE CODE	MOD	STATUS
01	SMITH	90000000A95001	23462708096	01				01
02	JONES	90000000A95002	23573621108	01				01
03								
04								

2059118056	22485297	0123456789
<small>CORRESPONDENCE REF #</small>	<small>DOCUMENT NUMBER</small>	<small>PROVIDER NUMBER</small>

**NOVEMBER 30, 2015**

Status Numbers and Messages	
Status	Message
01	Accepted for resubmission of denied claim or underpayment/overpayment.
02	Accepted. Tracer status letter will be generated.
03	Rejected. Only one CCN per crossover CIF allowed.

## Claims Inquiry Response Letter

A *Claims Inquiry Response* Letter indicating the status of the claim is sent to providers when the CIF/tracer is processed. The letter includes a 13-digit Correspondence Reference Number (CRN), which contains the Julian date the CIF/tracer was received and can be used to verify that the CIF/tracer was submitted within the six-month billing limit.

If the response letter states the claim cannot be located, resubmit the claim as an appeal. Enclose any necessary attachments, including a copy of the *Claims Inquiry Response* letter.

Providers may receive a *Claims Inquiry Response* letter requesting additional information. To submit a new CIF, follow the instructions in the response letter.

## When Not To Use A CIF

- Incorrect provider number was used
- All claims denied for National Correct Coding Initiative (NCCI)
- Denied inpatient claims
- Trace (CCS only without SAR claims)
- Suspended claims appearing on a current *Remittance Advice Details* (RAD) form
- Pharmacy Compound Claims:
  - POS network
  - RTIP
- The following RAD codes (Submit an *Appeal*)

Code	Message
0002	The recipient is not eligible for benefits under the Medi-Cal program or other special programs.
0010	This service is a duplicate of a previously paid claim.
0072	This service is included in another procedure code billed on the same date of service.
0095	This service is not payable due to a procedure, or procedure and modifier, previously reimbursed.
0314	Recipient not eligible for the month of service billed.
0326	Another procedure with a primary surgeon modifier has been previously paid for the same recipient on the same date of service.
0525	NCCI (National Correct Coding Initiative) void of a column 2 claim previously paid when a column 1 claim has been processed for the same provider and date of service.
9940	NCCI (National Correct Coding Initiative) claim line is billed with multiple NCCI modifiers.
9941	NCCI (National Correct Coding Initiative) column 2 procedure code is not allowed when column 1 procedure has been paid.
9942	NCCI (National Correct Coding Initiative) quantity billed is greater than the allowed MUE (Medically Unlikely Edit) quantity.

### NOTES

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## CIF Completion Tips

CIF Completion Reminders	All Inquiries	Adjustments	Crossover, Inpatient and Pharmacy Compounds	Denial	SOC	Tracer
Always enter an "X" in the box to indicate the claim type.	X					
Enter no more than four claim inquiries per form. <b>NOTE</b> This does not apply to crossover and inpatient claims.	X					
Fill out each line completely. Do not use ditto marks ("") or draw an arrow to indicate repetitive information.	X					
All information must be exactly the same as that on the RAD. For example, an incorrect ID number on the RAD should be copied exactly on the CIF.	X					
Only one claim line per CIF.			X			
Be sure the recipient ID number and Claim Control Number on the CIF exactly match the numbers on the RAD.	X					
RAD not required.					X	X
Enter the recipient's original ID (the number issued prior to being enrolled in a no-SOC program).		X			X	
Do not use the <i>Remarks</i> area for additional inquiries.	X					
State clearly and precisely what is being requested in the <i>Remarks</i> area.	X					
Always indicate the denial or adjustment reason code in the <i>Remarks</i> area.		X		X		
Secure documentation to the upper right-hand corner of the CIF.		X	X	X		
Do not attach any documentation.						X
Only original CIFs are accepted. Photocopies will be returned.	X					

## Appeal Form

The appeal process offers Medi-Cal providers who are dissatisfied with the processing of a claim, the resubmission of a claim or CIF a method for resolving their dissatisfaction.

An appeal must be submitted on an *Appeal* form (90-1). A separate appeal must be submitted for individual recipients.

### Appeal Form 90-1 Example

DO NOT STAPLE  
IN BAR AREA

**APPEAL**

TYPEWRITER  
ALIGNMENT  
 ELITE  PCA

(3) PROVIDER NAME/ADDRESS

ABC PROVIDER  
1234 MAIN STREET  
ANYTOWN CA 95823555

(1) APPEAL REFERENCE NUMBER

F.I. USE ONLY

READ INSTRUCTIONS ON REVERSE  
PRIOR TO COMPLETING AND SIGNING  
THIS FORM. DO NOT TYPE/MARK IN  
SHADED AREAS.

(4) PROVIDER NO.  
**0123456789**

(5) CLAIM TYPE  
CHECK ONE BOX ONLY

<input type="checkbox"/> 01 PHARMACY	<input type="checkbox"/> 04 HOSPITAL OUTPATIENT/ CLINIC
<input type="checkbox"/> 02 LTC	<input checked="" type="checkbox"/> 05 PHYSICIAN/ ALLIED
<input type="checkbox"/> 03 HOSPITAL INPATIENT	<input type="checkbox"/> 07 VISION

FASTEN  
HERE

(2) DOCUMENT NUMBER  
**GXXXXXXX**

TYPEWRITER  
ALIGNMENT  
 ELITE  PCA

(6) AS PROVIDED BY THE CALIFORNIA ADMINISTRATIVE CODE, TITLE 22, SECTION 51015 (b-d), I AM SUBMITTING AN APPEAL OF MY CLAIM AS DEFINED BELOW. ENCLOSED ARE ALL THE PERTINENT DOCUMENTS CORRESPONDING TO THIS APPEAL, INCLUDING COPIES OF THE CLAIM, EOB/RA, CIF's, MEDICARE EOMB/RA AND ANY PREVIOUS CORRESPONDENCE WITH THE MEDICAL FISCAL INTERMEDIARY.

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

PATIENT'S NAME OR (7) MEDICAL RECORD NO.	(8) PATIENT'S MEDICAL I.D. NO./SSN	(9) DELETE	(10) CLAIM CONTROL NO.	(11) DATE OF SERVICE	(12) EOB/RA CODE
SMITH	90000000A95001	<input type="checkbox"/> 01	1234567890123		
		<input type="checkbox"/> 02	1234567890124		
		<input type="checkbox"/> 03	1234567890125		
		<input type="checkbox"/> 04			
		<input type="checkbox"/> 05			
		<input type="checkbox"/> 06			
		<input type="checkbox"/> 07			
		<input type="checkbox"/> 08			
		<input type="checkbox"/> 09			
		<input type="checkbox"/> 10			
		<input type="checkbox"/> 11			
		<input type="checkbox"/> 12			
		<input type="checkbox"/> 13			
		<input type="checkbox"/> 14			

(13) **REASON FOR APPEAL:** (ENCLOSED ALL SUPPORTING DOCUMENTS, INCLUDING CLAIM COPY)

1. PLEASE SEE ATTACHED REPORT. WE SUBMITTED A  
CIF BUT THE CLAIM WAS DENIED AGAIN FOR  
DOCUMENTATION. PLEASE RECONSIDER.

2. QUANTITY BILLED WAS 2, ONLY PAID 1. PLEASE  
ADJUST THIS UNDERPAYMENT.

3. BILLED IN ERROR. PLEASE RETRACT PAYMENT.

(14) COMMON APPEAL REASON  
CHECK ONLY ONE (IF APPLICABLE)

<input type="checkbox"/> ELIGIBILITY	(POE ATTACHED)
<input type="checkbox"/> TAR DENIAL	(TAR ATTACHED)
<input type="checkbox"/> CROSSOVER	(EOMB ATTACHED)
<input type="checkbox"/> ADJUSTMENT REQUEST	(PAID WARRANT ATTACHED)

THIS IS TO CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS TRUE, ACCURATE, AND COMPLETE AND THAT THE PROVIDER HAS READ, UNDERSTANDS, AND AGREES TO BE BOUND BY AND COMPLY WITH THE STATEMENTS AND CONDITIONS CONTAINED ON THE BACK OF THIS FORM.

(15) *Jane Smith* 030115

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM. DATE

FORM# 90-1 (3/07)

Appeals should be mailed in the purple and white envelopes available from the FI. Providers should send appeals to the FI at the following address:

Attn: Appeals Unit  
Xerox State Healthcare, LLC  
P.O. Box 15300  
Sacramento, CA 95851-1300

All supporting documentation must be legible. A copy of any of the following attachments as they apply to the claim is acceptable:

- Corrected claim, if necessary
- RADs pertaining to the claim history
- *Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)*
- Other Health Coverage (OHC) payments or denials
- All CIFs, Claims Inquiry Acknowledgements, *Claims Inquiry Response* letters or other dated correspondence to and from the FI to document timely follow-up
- Report for "By Report" procedures
- Manufacturer's invoice or catalog page
- Completed sterilization *Consent Form* (PM 330)
- *Treatment Authorization Request (TAR)* or Service Authorization Request (SAR)

An appeal received on or after October 1, 2015, by the FI requires an ICD indicator of "0" on the claim attached to it if the attached claim is submitted with an ICD-10-CM diagnosis code. If the ICD indicator is not on the claim, the appeal will be rejected.

The FI will acknowledge appeals within 15 days of receipt and make a decision within 45 days of receipt. If a decision is not made within 45 days, the appeal is referred to the Professional Review Unit for an additional 30 days.

**NOTES**

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### Appeal Form Completion Process

Complete the fields on the *Appeal* form according to the type of inquiry. Resubmission, underpayment and overpayment requests for the same recipient may be combined on one form.

Appeal Form 90-1	
Fields	Instructions
3, 4, 5, 7, 8, 10, 11 and 12	These fields are required for all appeal types.
4, 5, 8 and 10	<i>Provider Number, Claim Type, Patient's Medi-Cal ID Number and Claim Control Number</i> are completed to process an appeal. If these fields are left blank, providers may receive an appeal rejection letter requesting resubmission of a corrected <i>Appeal</i> form and all supporting documentation, proof of timely follow-up and submission.

**NOTE**

The correct recipient ID number must be entered in Box 8 (*Patient's Medi-Cal ID No.*) even if the RAD reflects an incorrect recipient ID number.

### Appeal Form Completion Tips

Appeal Form Tips	
Appealing a Denial	If appealing a denial, enter the denial code from the RAD in Box 12.
Underpayment and Overpayment	If requesting reconsideration of an underpayment or overpayment, enter the payment code from the RAD in Box 12.
Adjustments	If requesting an adjustment, attach a legible copy of the original claim form, corrected if necessary, and a copy of the corresponding paid RAD. If requesting an overpayment adjustment because the patient named is not a provider's patient, attach only a copy of the paid RAD.
Signatures	Sign and date the bottom of the form. All appeals must be signed by the provider or an authorized representative. Appeals submitted without a signature will be returned to the provider.

**NOTES**

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## Medi-Cal Provider Appeals Packet Checklist

Instructions: Before mailing an appeal to Medi-Cal please review this checklist and make sure you have all pertinent documents. Simply mark an  next to all that apply.

- I have reviewed the *Appeal Form Completion* section in the Part 2 manual for *Appeal* form (90-1) completion instructions
- Medi-Cal *Appeal* form 90-1 complete
- If appeal is for a claim that may be an underpayment or overpayment, then enter payment code found on the RAD in Box 12
- If appeal is for claim denial then enter the denial code from the RAD in Box 12 on Form 90-1
- For an overpayment adjustment because the patient named is *not* the provider's patient, then attach *only* a copy of the paid RAD to *Appeal* form 90-1
- Copy of original claim
- Remittance Advice Details*
- Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN)*
- Treatment Authorization Request (TAR) or Service Authorization Request (SAR)*
- Health coverage payments or denials
- Claims Inquiry Form*
- Claims Inquiry Acknowledgements
- Claims Inquiry Response* letters
- All dated correspondence sent to Medi-Cal
- All dated correspondence received from Medi-Cal that documents timely follow-up (*must be on Xerox letterhead*)
- Report for "By Report" procedures
- Manufacturer's invoice or catalog page
- Lab reports showing different times or sites for multiple procedures
- If appeal is for a claim that bills for twins, ensure each twin (Twin A or Twin B) is correctly indicated on the claim in the *Patient's Name* field (Box 2).
- Attach proof of recipient eligibility if date of service (DOS) is over 15 months or last denial was for eligibility
- Completed sterilization *Consent Form* (PM 330)
- I have signed and dated the bottom of *Appeal* form 90-1 (*All appeals must be signed by the provider or an authorized representative for the provider. Appeals submitted without a signature will be returned to the provider*)



# Acronyms

<b>ACF</b>	Attachment Control Form
<b>ACN</b>	Attachment Control Number
<b>AEVS</b>	Automated Eligibility Verification System
<b>AR</b>	Adjudication Response
<b>BIC</b>	Benefits Identification Card
<b>CA-MISS</b>	California Medicaid Management Information System
<b>CCN</b>	Claim Control Number
<b>CCS</b>	California Children's Services
<b>CHDP</b>	Child Health and Disability Prevention
<b>CIF</b>	Claims Inquiry Form
<b>CIN</b>	Client Index Number
<b>CMC</b>	Computer Media Claims
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>CMSP</b>	County Medical Services Program
<b>COBC</b>	Coordination of Benefits Contractor
<b>CPSP</b>	Comprehensive Perinatal Services Program
<b>CPT-4</b>	Current Procedural Terminology 4th Edition
<b>CSU</b>	Correspondence Specialist Unit
<b>DHCS</b>	Department of Health Care Services
<b>DME</b>	Durable Medical Equipment
<b>DOB</b>	Date of Birth
<b>DOI</b>	Date of Issue
<b>EOB</b>	Explanation of Benefits
<b>EOMB</b>	Explanation of Medicare Benefits
<b>ERA</b>	Electronic Remittance Advice
<b>EVC</b>	Eligibility Verification Confirmation
<b>FI</b>	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
<b>GHPP</b>	Genetically Handicapped Persons Program
<b>HAP</b>	Health Access Program
<b>HCFA</b>	Health Care Financing Administration
<b>HCP</b>	Health Care Plan

<b>HCPCS</b>	Healthcare Common Procedure Coding System
<b>HIC</b>	Health Insurance Claim
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>ICD-9-CM</b>	International Classification of Disease, 9th Revision, Clinical Modification
<b>ICD-10-CM</b>	International Classification of Disease, 10th Revision, Clinical Modification
<b>ICF</b>	Intermediate Care Facility
<b>KDE</b>	Key Data Entry
<b>LTC</b>	Long Term Care
<b>LMP</b>	Last Menstrual Period
<b>LOA</b>	Letters of Authorization
<b>MCP</b>	Medi-Cal Managed Care Plans
<b>NCCI</b>	National Correct Coding Initiative
<b>NCPDP</b>	National Council for Prescription Drug Programs
<b>NDC</b>	National Drug Code
<b>NF</b>	Nursing Facility
<b>NMP</b>	Non-Physician Medical Practitioner
<b>NPI</b>	National Provider Identifier
<b>NUCC</b>	National Uniform Claim Committee
<b>OCR</b>	Optical Character Recognition
<b>OHC</b>	Other Health Coverage
<b>PI</b>	Pricing Indicator
<b>POE</b>	Proof of Eligibility
<b>POS</b>	Point of Service
<b>RAD</b>	Remittance Advice Details
<b>RR</b>	Responsible Relative
<b>RTD</b>	Resubmission Turnaround Document
<b>RTIE</b>	Real Time Internet Eligibility
<b>SAR</b>	Service Authorization Request
<b>SOC</b>	Share of Cost
<b>SNF</b>	Skilled Nursing Facility
<b>TAR</b>	Treatment Authorization Request
<b>TCN</b>	TAR Control Number
<b>TSC</b>	Telephone Service Center
<b>UB</b>	Universal Billing