

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

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Genetic Screening Billing Examples: CMS-1500

Examples in this section are to assist providers in billing for genetic screening on the *CMS-1500* claim form. Refer to the *Genetic Screening* section of this manual for detailed policy information. Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

Billing Tips: When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts. If requested information does not fit neatly in the *Reserved for Local Use* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

**Newborn Metabolic
Screening Panel
(HCPCS Code S3620)**

*Figure 1. Billing for newborn metabolic screening panel
(HCPCS code S3620).*

This is a sample only. Please adapt to your billing situation.

Newborn screening tests for metabolic disorders detectable via Tandem Mass Spectrometry (amino acid disorders such as phenylketonuria [PKU], organic acid disorders and fatty acid oxidation disorders), galactosemia, primary congenital hypothyroidism, hemoglobinopathies, and classical congenital adrenal hyperplasia are reimbursable only when HCPCS code S3620 is billed with modifier 90 (*California Code of Regulations*, Title 17, Section 6500). The newborn metabolic screening panel (code S3620) is a once-in-a-lifetime procedure for infants under age 1.

Providers should enter the mother's Medi-Cal ID number in the *Insured's ID Number* field (Box 1A).

Providers should indicate that the newborn is using the mother's Medi-Cal ID number by entering "Newborn Infant Using Mom's ID" in the *Reserved for Local Use* field (Box 19). In the *Outside Lab?* field (Box 20), check the *Yes* box.

Code S3620 is billed with modifier 90 on claim line one in the *Procedures, Services, or Supplies* field (Box 24D).

Enter the CLIA-certified laboratory's NPI in the *Rendering Provider ID NPI* field (Box 24J, unshaded area).

Providers should enter the billing provider's address and phone number in the *Billing Provider Info and Phone Number* field (Box 33) and NPI in Box 33A.

Note: The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be reimbursed correctly.

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <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 #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 90000000A95001	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE JANE		3. PATIENT'S BIRTH DATE SEX MM DD YY M F 05 21 07 M <input type="checkbox"/> F <input checked="" type="checkbox"/>	
4. INSURED'S NAME (Last Name, First Name, Middle Initial) DOE MARY		5. PATIENT'S ADDRESS (No., Street) 1234 MAIN STREET	
6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input checked="" type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		9. INSURED'S ADDRESS (No., Street)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M F		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY.	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE NEWBORN INFANT USING MOM'S ID		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. V302		20. OUTSIDE LAB? \$ CHARGES <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER MM DD YY MM DD YY		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER	
1 06 12 07 11 S3620 90		F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID QUAL J. RENDERING PROVIDER ID. # 10275 1 NPI 1234567890	
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 \$ 10275	
29. AMOUNT PAID \$		30. BALANCE DUE \$ 10275	
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>Jane Smith</i> DATE 06/30/07		32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.	
33. BILLING PROVIDER INFO & PH # (916) 555-5555 JANE SMITH 1027 MAIN STREET ANYTOWN CA 958235555		a. 0123456789 b.	

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Figure 1. Billing for Newborn Metabolic Screening Panel (HCPCS Code S3620).