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## UB-04 Special Billing Instructions for Outpatients

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This section includes information about “By Report” attachments to claims, “from-through” billing and submitting claims for *Treatment Authorization Request*-approved procedures. This information is designed to supplement the explanations in the *UB-04 Completion: Outpatient Services* section of this manual.

### **“By Report” Attachments**

The Medical Review Unit is unable to process “By Report” claims without the following information on the “By Report” attachment:

- Patient name.
- Date of service.
- Procedure number (list supplemental procedures if applicable).
- Operating report and operating time, or procedure report. Each report must include a description of the actual procedure performed on the patient and the results of the procedure. *Pro forma* or “canned” reports are unacceptable.
- Estimated follow-up days required.
- Size, number and location of lesions (if applicable).
- When billing unlisted “By Report” procedures (no specific description of service, such as CPT® code 36299 [unlisted vascular injection procedure]), also state the time involved, the nature and purpose of the procedure or service and how it relates to diagnosis.

### **Using Remarks Field In Place of Attachments**

“By Report” claim submissions do not always require a claim attachment. For some procedures, entering information in the *Remarks* field (Box 80) of the claim may be sufficient.

**Note:** Many radiology and pathology “By Report” procedures require only a description in the *Remarks* field (Box 80) of the claim.

### **POS and Internet**

Point of Service (POS) printouts and Internet eligibility responses, with Eligibility Verification Confirmation (EVC) numbers, are not required as attachments unless the claim is over 1 year old.

## **“From-Through” Billing**

From-through” billing is a method of billing that allows providers to bill for the same service rendered on different dates of service, without having to complete a separate claim line for each date of service. Only specific services identified in applicable policy sections may be billed in this manner.

### **Billing Procedures**

Inappropriate use of the “from-through” billing format may result in claim denial. Refer to *Figure 1. “From-Through” Billing Example* on the following page.

- **Line 1:** Begin the procedure description in the *Description* field (Box 43). Enter the from date of service in the *Service Date* field (Box 45) and align it with the beginning of the procedure description. No other information is entered on the first line.
- **Line 2:** Continue procedure description started on line 1, if necessary, and list all dates of service. Enter the procedure code for service rendered in the *HCPCS/Rate* field (Box 44), followed by the through date in the *Service Date* field (Box 45).

The number of units being billed is entered in the *Service Units* field (Box 46). If the quantity exceeds 99, bill the remaining services on individual claim lines or in additional “from-through” format(s). Enter the total of the Service Units times the maximum allowable amount for the designated procedures in the *Total Charges* field (Box 47).

**Note:** For electronic billing, enter the description in the *Remarks* field (Box 80) and a “1” in the *Service Units* field.

Complete the rest of the fields as instructed in the appropriate policy section and/or the *UB-04 Completion: Outpatient Services* section in this manual.

### **Consecutive/Non-Consecutive Days**

“From-through” billing may be used for both consecutive and non-consecutive days of service.

## Unit Type as “Month”

Procedure codes with a unit type of “Month” must be billed using the “from-through” method. *Figure 1*, below, is an example of “From-Through” billing.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1	<b>SERVICES FOR JULY</b>		<b>070307</b>		
2	<b>7/3, 7/7, 7/13, 7/19, 7/24, 7/31</b>	<b>Procedure code</b>	<b>073107</b>	<b>6</b>	<b>129000</b>
3					
4					

**Figure 1:** “From-Through” Billing Example.

## Line-Item Billing

Line-item billing is illustrated in *Figure 2* below. This method must be used for all services on the *UB-04* claim, except when using the “from-through” billing method.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1	<b>UNLISTED THERAPEUTIC INJECT.</b>	<b>90772</b>	<b>070307</b>	<b>1</b>	<b>4000</b>
2					
3					
4					

**Figure 2:** Line-Item Billing Example.

## Submitting Claims for TAR Authorized Services

Providers bill Medi-Cal for *Treatment Authorization Request* (TAR)-authorized services only after receiving the approved TAR. If the TAR approval process causes a delay in submitting claims, providers (except LEA providers) may request an extension of the usual six-month billing limit by entering the appropriate delay reason code in the *Delay Reason* field (Box 37A) of the claim.

To submit a claim for services authorized by a TAR, providers should:

- Ensure that the procedure codes, modifiers and dates of service on the claim match exactly those shown on the approved TAR. The cumulative number of units billed (for each procedure) against a particular TAR must not exceed the number of units approved by the TAR.

- Enter the 11-digit TAR Control Number (TCN) from the approved TAR in the Treatment Authorization Codes field (Box 63) on the UB-04 claim. Enter the TCN only from a 50-1 TAR form. TCNs from other TAR forms (18-1 or 20-1) are used only by hospitals and facilities.
- Enter the TCN on all claims for services authorized on one TAR, even if the services are billed separately.

### **Multiple TARs/Separate Claims**

Items or procedures approved on separate TAR forms must be billed on separate claim forms. Items covered on two TARs must not be combined on a single claim. See “Multiple TARs” in the *TAR Completion* section of this manual.

### **“From-Through” Billing**

Providers must not mix the TAR-authorized and non-TAR-authorized services in the same “from-through” billing period.

### **Submitting Copies of TARs**

Providers must not submit copies of TARs with claims as proof of authorization. Instead, providers should accurately and legibly copy the entire 11-digit TAR Control Number in the TAR control box on the claim form. Omissions, errors or illegibility will cause claim denial.

### **TAR Copy Exceptions**

Providers may submit copies of TARs with appeals and *Claims Inquiry Forms* (CIFs) to show that there is an error in the TAR information.

### **TAR Corrections for TARs Over One Year Old**

Providers may request to correct or modify recipient information on a TAR within a year of the TAR’s original approval date. The Department of Health Care Services (DHCS) consultant will not change the recipient’s Medi-Cal ID number, Social Security Number (SSN), name, date of birth or sex if the TAR is more than one year old.

### **Mismatched TAR and Claim Data**

If a claim is denied because the recipient data on the claim does not match the recipient data on the TAR, providers may request claim reconsideration by attaching a copy of a TAR to a CIF.

## **TARs and Medi-Services**

Providers must submit two separate claims if a combination of Medi-Services and TAR-authorized services are being billed to substantiate services rendered to a recipient during a single billing period. For example, a podiatrist sees a patient in his office on September 6, reserving a Medi-Service, and then sees the patient on September 16 and 30 in a Nursing Facility Level B (NF-B) under an approved treatment plan. One claim must be submitted for the Medi-Service office visit. A second claim must be submitted for the NF-B visits, indicating the TAR Control Number on the claim.

## **Billing TARs and Non-TAR Authorized Procedures**

The following information relates to billing TAR and non-TAR authorized procedures.

### **DME and Medical Supplies**

TAR-authorized procedures for Durable Medical Equipment (DME) and Medical Supplies are billed on a separate claim from non-TAR authorized procedures.

**Note:** Claims submitted to Medi-Cal for DME, medical supplies, incontinence medical supplies and prosthetic and orthotic appliances identified with a single asterisk in the *California Code of Regulations* (CCR), Title 22, Section 51515, shall not exceed an amount that is the lesser of (1) the usual charges made to the general public or (2) the net purchase price of the item, which must be documented in the provider's books and records, plus no more than a 100 percent markup (CCR, Title 22, Section 51008.1).

Providers are also prohibited from submitting claims for DME, supplies and appliances that were obtained at no cost (CCR, Title 22, Section 51008.1). This regulation does not alter Medi-Cal's statutory or regulatory maximum reimbursement rates.

Per Title 22, *California Code of Regulations* (CCR), Section 51321(g): Authorization for Durable Medical Equipment shall be limited to the lowest cost item that meets a patient's medical needs.

### **Surgical Procedures**

TAR and non-TAR surgical procedure codes (HCPCS codes Z1032 thru Z1038, Z1200 thru Z1212 or CPT series 10000 thru 69999) and their corresponding modifiers, are billed on the same claim when multiple surgeries are performed on the same date of service for the same recipient.

## **Identical Services Billed for the Same Date of Service**

Identical services billed for the same date of service are considered duplicate billings. Only one service will be reimbursed.

When a service is legitimately rendered more than once on the same date of the service (before and after X-rays, glucose tolerance testing, ova and parasite tests, etc.), providers must include documentation with the claim explaining why the service was rendered more than once. This information may be entered in the *Remarks* field (Box 80) or on an attachment to the claim. When billing electronically, enter the statement in the *Remarks* area.

**Note:** A statement indicating “this service is not a duplicate” is not sufficient to clarify why the service was rendered more than once.

Providers who receive a denial for duplicate services may submit a *Claims Inquiry Form* (CIF) for claim reconsideration. The CIF must include documentation or a statement in the *Remarks* area explaining why the service was rendered more than once.

**<<Legend>>**

<<Symbols used in the document above are explained in the following table.>>

<b>Symbol</b>	<b>Description</b>
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.