
CMS-1500 Special Billing Instructions

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This section includes information about “By Report” attachments to claims, “from-through” billing and submitting claims for *Treatment Authorization Request* (TAR)-approved procedures by Medical Services, Allied Health and Pharmacy providers. This information is designed to supplement the explanations in the *CMS-1500 Completion* 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.

Allied Health and Pharmacy Providers

Also refer to the Durable Medical Equipment (DME), medical supplies, and orthotics and prosthetics sections in the appropriate Part 2 manual for additional “By Report” requirements.

Using Additional Claim Information Field (Box 19) In Place of Attachments

“By Report” claim submissions do not always require a claim attachment. For some procedures, entering information in the *Additional Claim Information* field (Box 19) of the claim may be sufficient.

Note: Many radiology and pathology “By Report” procedures require only a description in the *Additional Claim Information* field (Box 19) 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. Enter the beginning date of service in the “From” column in the *Date(s) of Service* field (Box 24A). In Box 24A, enter the ending date of service in the “To” column. Individually list each date that a service was rendered during the entire “from-through” period in the *Additional Claim Information* field (Box 19). Complete the rest of the fields as instructed in the appropriate policy section and/or the *CMS-1500 Completion* section of this manual.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) January: 01/02, 01/10, 01/30											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) A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____											22. RESUBMISSION CODE		ORIGINAL REF. NO.							
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY											23. PRIOR AUTHORIZATION NUMBER									
B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER											F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
1	01	02	15	01	30	15	21		XXXXX			1290	00	6		NPI				
2																NPI				
3																NPI				
4																NPI				

Figure 1: “From-Through” Billing Example.

Consecutive/ Non-Consecutive Days

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

Line-Item Billing

Line-item billing is illustrated in *Figure 2* below. This method must be used for all services on the *CMS-1500*, except when using the "from-through" billing method.

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)											20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES		
DIALYSIS															
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. _____															
I. _____ J. _____ K. _____ L. _____															
23. PRIOR AUTHORIZATION NUMBER															
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 F. \$ CHARGES G. DAYS OF UNITS H. ICD ID. QUAL. J. RENDERING PROVIDER ID. #															
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER	DIAGNOSIS	POINTER	\$ CHARGES	DAYS OF UNITS	ICD ID. QUAL.	RENDERING PROVIDER ID. #
01	02	15				65		XXXXX				130 00	1	NPI	
01	06	15				65		XXXXX				130 00	1	NPI	
01	10	15				65		XXXXX				25 00	1	NPI	
														NPI	

Figure 2: Line-Item Billing Example.

Submitting Claims for TAR-Authorized Services

Providers bill Medi-Cal for TAR-authorized services only after receiving the approved TAR. If the TAR approval process causes a delay in submitting claims, providers may request an extension of the usual six-month billing limit by entering the appropriate delay reason code in the *EMG (Delay Reason)* field (Box 24C) of the claim. Refer to the *CMS-1500 Completion* section for further instructions about submitting a delay reason code.

To submit a claim for services authorized by a TAR:

- 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 *Prior Authorization Number* field (Box 23) on the *CMS-1500*. 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 the appropriate Part 2 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 via the TAR Processing Center to correct or modify recipient information on a *Treatment Authorization Request* (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 *Treatment Authorization Request* (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 (NF) Level 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 TAR 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 form from non-TAR authorized procedures.

Note: Claims submitted to Medi-Cal for DME, medical supplies, incontinence medical supplies and orthotic and prosthetic 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 also are 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.

Note: 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 Z1032 thru Z1038, Z1200 thru Z1212 or CPT series 10000 thru 69999) and their corresponding modifiers are billed on the same claim form 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, and 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 *Additional Claim Information* field (Box 19) 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.>>

Symbol	Description
<<	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.