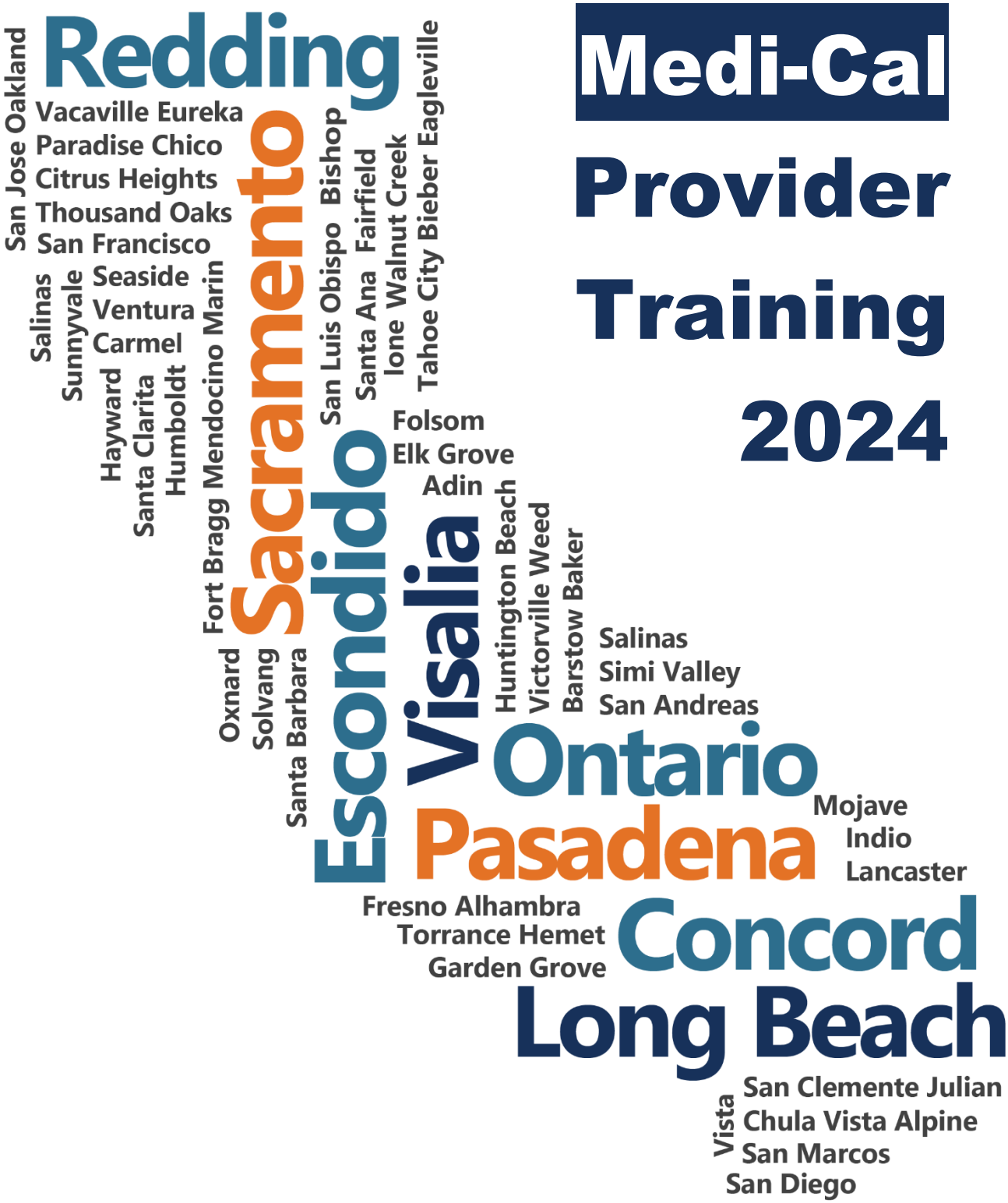


Medi-Cal Provider Training 2024

Billing Basics

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

The Outreach and Education services is made up of Provider Field Representatives located throughout California and includes the Small Provider Billing Assistance and Training Program staff, who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment. See the below additional tools and free services available to your provider community.

Medi-Cal Learning Portal (MLP)

Explore the Medi-Cal Learning Portal (MLP) that offers Medi-Cal providers and billers self-paced online training about billing basics, related policies and procedures; new initiatives and any significant changes to the Medi-Cal program.

How can you get started using the MLP?

- First time users must complete a one-time registration at www.learn.medi-cal.ca.gov
- After logging in, you will be able to RSVP for training events or view eLearning courses
- Refer to the Medi-Cal Learning Portal (MLP) Job Aid or the Medi-Cal Learning Portal (MLP) User Guide for detailed instructions

How can you benefit from using the MLP?

- Significantly reduce billing errors by learning billing best practices
- Quizzes that test your knowledge
- Practice your skills using interactive activities

Free Services for Providers

Provider Seminars and Webinars

Provider Training Seminars and Webinars offer basic and advanced billing courses for all provider types. Seminars also offer a free billing assistance called the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Provider Field Representative. The dates and locations for the annual provider training seminars and webinars can be found on the events calendar in the MLP tool and in the News area on www.medi-cal.ca.gov.

Provider Field Representatives

Receive one-on-one assistance from Provider Field Representatives who live and work in cities throughout California. Provider Field Representatives are available to visit providers at their office to assist with billing needs and/or provide custom billing training to office staff.

Small Provider Billing Assistance and Training Program

The Small Provider Billing Assistance and Training Program is 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 Small Provider 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!

Table of Contents

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 POS response information regarding eligibility, Medi-Service and Share of Cost (SOC) transactions

Acronyms

A list of current acronyms is in the *Appendix* section of each complete workbook.

Recipient Eligibility Terms

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

Table of Provider Manual and POS 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)
BIC ID Number	Subscriber ID
Client Identification Number (CIN)	Subscriber ID

Notes:

Benefits Identification Card

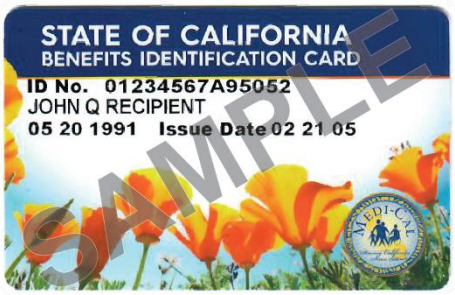
BIC Overview

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 POS network 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.

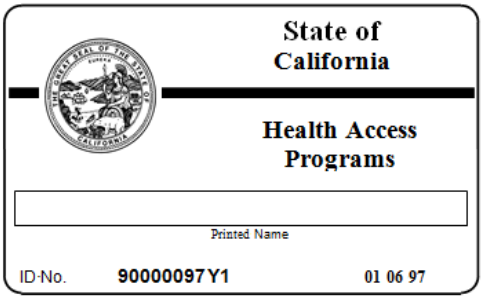
Below are three valid BIC samples. The new design, featuring the California poppy without gender, will be provided to newly eligible recipients and recipients requesting replacement cards. There are no plans to provide the new card to the entire Medi-Cal population.

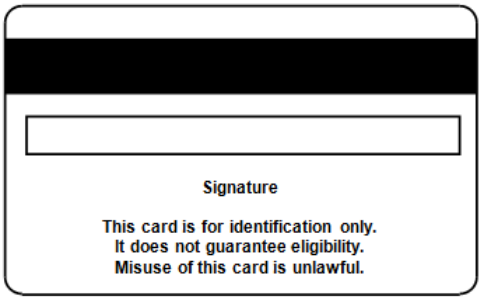


Providers should accept all BIC designs and must continue to verify eligibility.

When a provider verifies an individual is eligible to receive Medi-Cal benefits, (by this act) the provider is accepting the individual as a Medi-Cal recipient. If the provider is unwilling to accept an individual as a Medi-Cal recipient, the provider has no authority to access confidential eligibility information.

In addition to the Medi-Cal Fee-for-Services program, there is an additional program known as Health Access Program (HAP) that offers a HAP Identification Card (ID) for services that are specific to that program. Please refer to the Family PACT eligibility guidelines that can be found in the Policies, Procedures and Billing Instructions (PPBI) manual.





In addition to a provider verifying that an individual is eligible to receive Medi-Cal benefits, the provider must make a “good faith effort” to verify the recipient’s identification by matching the recipient’s name and signature on their HAP/BIC card against the signature on a valid California driver’s license, a California ID issued by the Department of Motor Vehicles, another acceptable picture ID card or other credible identification documentation.

A mother’s BIC, whether for restricted or full-scope benefits, can be used to bill full-scope medical services rendered to her newborn during the month of delivery and the following month. A separate identification number must be issued to the infant following the two-month grace period so that services can be billed separately for each recipient.

Exception

The identification requirement does not apply when a recipient is receiving emergency services, is 17 years of age or younger receiving Minor Consent services or is in a Long-Term Care (LTC) facility.

The provider must document the “good faith effort” by making a copy of the BIC and a copy of the picture identification card or other credible document of identification that was used to compare signatures.

California Children’s Services (CCS) clients enrolled in the CCS program are issued a BIC. If a CCS client also has Medi-Cal, the CCS eligibility will be displayed along with the Medi-Cal eligibility.

Children eligible for CCS will be identified by aid codes unique to the CCS program.

Possession of a BIC is not proof of Medi-Cal eligibility because it is a permanent form of identification and is retained by the recipient, even when he or she is not eligible for the current month.

When using the BIC in conjunction with the Medi-Cal POS network, the following information can be identified:

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

BIC and temporary paper Medi-Cal ID cards must not be altered by either the recipient or provider. If a recipient presents a card that is photocopied or contains erasures, strikeouts, white-outs, type overs or any other form of alteration, providers should request that the recipient obtain an unaltered card and check other identification to ensure that the patient is the Medi-Cal recipient. Do not accept altered BIC and temporary paper Medi-Cal ID cards as proof of eligibility.

All providers are expected to use the ID 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).

Reminder: Recipient Eligibility Verification

Providers are reminded that they must verify eligibility every month for each recipient who presents a plastic BIC or paper card for Immediate Need or Minor Consent. An internet eligibility response may be kept as evidence of proof of eligibility for the month for Immediate Need or Minor Consent.

For all other program eligibility verifications other than Immediate Need or Minor Consent, Providers **must** verify eligibility on the date of service even if eligibility was previously verified for the month.

Notes:

Temporary Paper Medi-Cal ID Cards

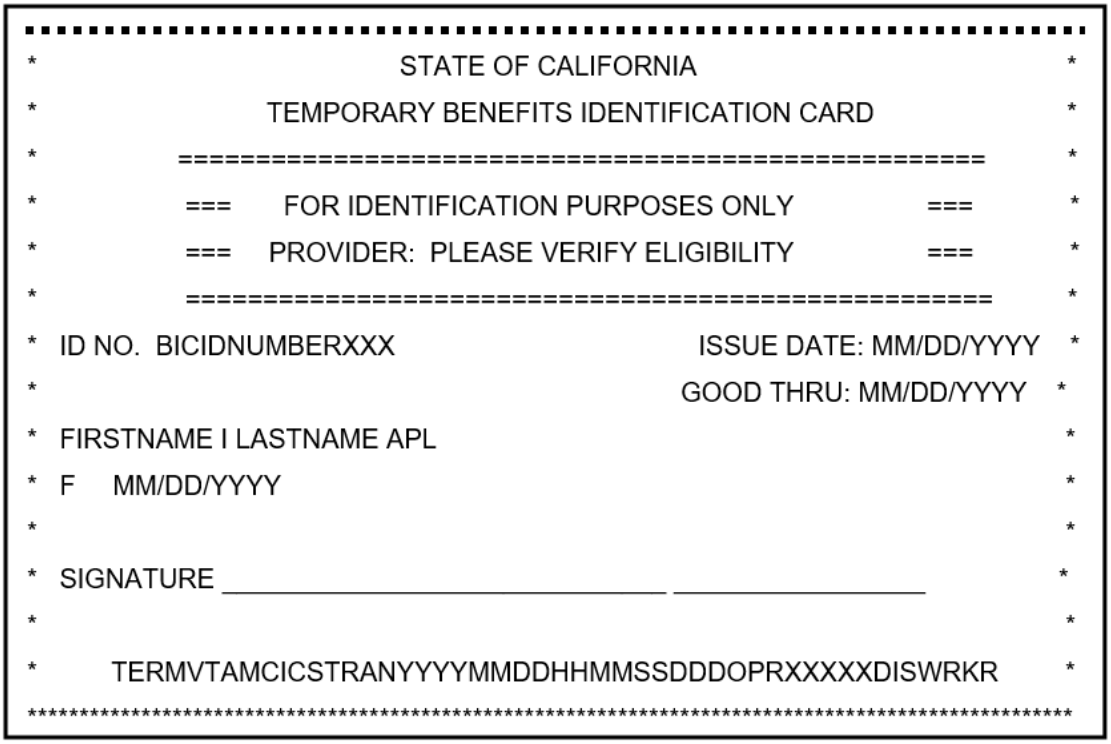
In some cases, recipients are issued temporary paper Medi-Cal ID cards from either the County Welfare Department or a Presumptive Eligibility (PE) Provider. The card contains a 14-digit ID number and is used just like a plastic BIC.

Temporary paper identification cards are issued to the following:

- 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
- Recipients that are enrolled in a PE program

Sample Paper ID Card for Immediate Need and Minor Consent Recipients issued by the county.

(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.

Presumptive Eligibility Programs

Medi-Cal PE programs provide qualified individuals immediate, temporary Medi-Cal coverage based on the individual's self-attested preliminary information. Qualified PE providers approved by DHCS make PE determinations. The PE programs include:

- BCCTP (Breast & Cervical Cancer Treatment Program)
- CHDP (Child Health & Disability Prevention Program)
- EWC (Every Woman Counts)
- PE4PW (Presumptive Eligibility for Pregnant Women) and
- HPE (Hospital Presumptive Eligibility)

Qualified PE providers enter the PE applicant's information via Transaction Services into the Application Web Portal on the Medi-Cal Provider website *(www.medi-cal.ca.gov)* and provide PE applicants a *Single Streamlined Application* (SSApp) (CCFRM604) to apply for Medi-Cal or other health coverage.

Please refer to the specific PE program provider manual sections for detailed PE requirements.

Child Health and Disability Prevention (CHDP) Gateway

Pre-Enrollment

CHDP providers use the CHDP Gateway process to temporarily pre-enroll CHDP-eligible children and youth in fee-for-service, full-scope Medi-Cal at the time of a scheduled CHDP health assessment visit. Eligibility is based on age, household composition and family income. Services are available beginning on the date eligibility is determined.

Infant Enrollment

The CHDP Gateway process also allows the same CHDP Gateway transaction to automatically enroll eligible infants under one year of age into Medi-Cal without their parent(s) having to complete an SSApp. Eligible infants are those whose mothers had Medi-Cal eligibility at the time of delivery and continue to reside in California. Eligible infants receive full-scope, no cost Medi-Cal until their first birthday.

Note: Refer to the *Gateway Transactions Overview* (gate trans) section of the CHDP provider manual and the CHDP Gateway Transaction user guides for additional CHDP Gateway information.

Hospital Presumptive Eligibility (HPE)

The HPE program provides qualified individuals immediate access to temporary, no-cost Medi-Cal services while individuals apply for permanent Medi-Cal coverage or other health coverage. Qualified HPE providers approved by DHCS make HPE determinations via the HPE Application Web Portal.

On the day approved for HPE, individuals receive a temporary paper BIC to sign and receive immediate, temporary HPE coverage. The HPE enrollment period ends on the last day of the following month in which the individual was approved for HPE if an SSApp was not submitted. If an Insurance Affordability Application was submitted, HPE services will continue until an eligibility determination is made (approved or denied) on the application.

Presumptive Eligibility for Pregnant Women (PE4PW)

The PE4PW program allows Qualified Providers (QPs) to grant immediate, temporary Medi-Cal coverage for specific ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income, pregnant recipients, pending their formal Medi-Cal application.

The PE4PW enrollment period ends on the last day of the following month in which the individual was determined eligible for PE4PW if an insurance affordability application was not submitted. If an insurance affordability application was submitted, services will continue until determination is made on the insurance affordability application.

Notes:

Share of Cost (SOC)

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.

If the Medi-Cal eligibility verification system indicated a recipient has a SOC, the SOC balance must be met or obligated before a recipient is eligible for Medi-Cal benefits.

Recipient SOC amounts vary according to income and dependents and can change from month to month. This SOC amount 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 in Part 1 of the Medi-Cal Provider Manual. The *Aid Codes Master Chart* (aid codes) was developed for use in conjunction with the Point of Service Network (POS) Providers must submit an inquiry to POS to verify a recipient’s eligibility for services.

County Codes

The Medi-Cal eligibility verification system displays a county code for the recipient. This county code identifies the county whose county department is responsible for maintaining the current county case record for Medi-Cal eligibility for a person or family. The county of responsibility may be different from the county of residence. The county of residence indicates the county the individual physically resides in.

County codes can assist in identifying if the county is a managed care county that requires recipients to enroll in a Managed Care Plan (MCP).

Managed Care Plans (MCPs)

Medi-Cal recipients enrolled in contracted 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.

All recipients receive a health plan card that identifies the member's primary care physician in addition to a BIC. In most cases, the recipient presents both cards when receiving services.

Services excluded from the plan's contract require billing through the fee-for-service program, which may require prior authorization.

The *MCP: Code Directory* (mcp code dir) section 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.

Billing Notice

Most providers may no longer bill Medi-Cal or CCS using a recipient's SSN. Claims submitted with a recipient's SSN will be denied.

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
- 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.

To log into Medical Services, the first step is to access Transaction Services. Navigate to the Medi-Cal Provider Portal.

1. Enter the email address and select **Next.**

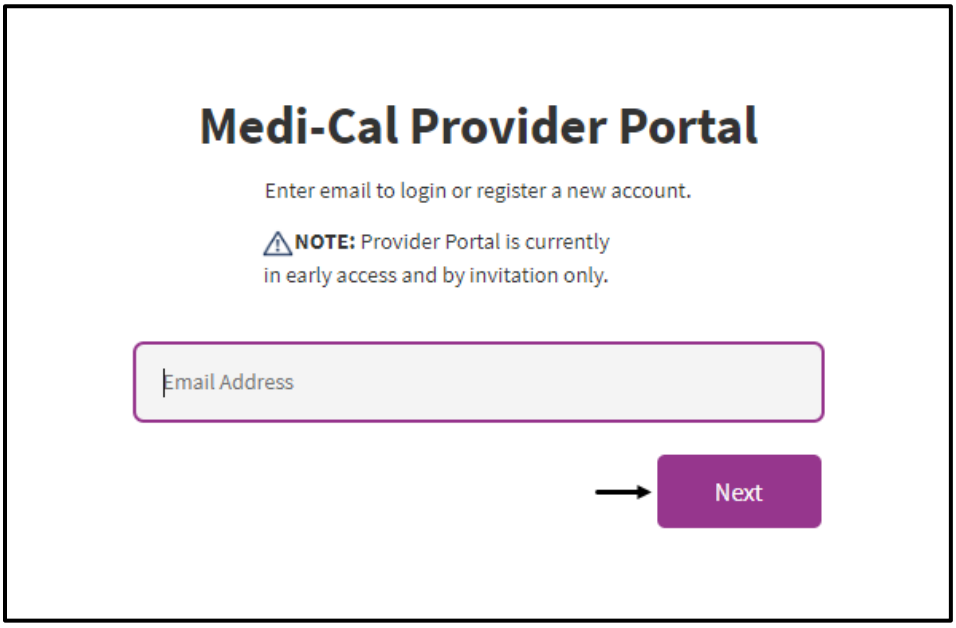


Figure 1.1: Provider Portal login.

2. On the Login screen enter the Password and select **Log In.**

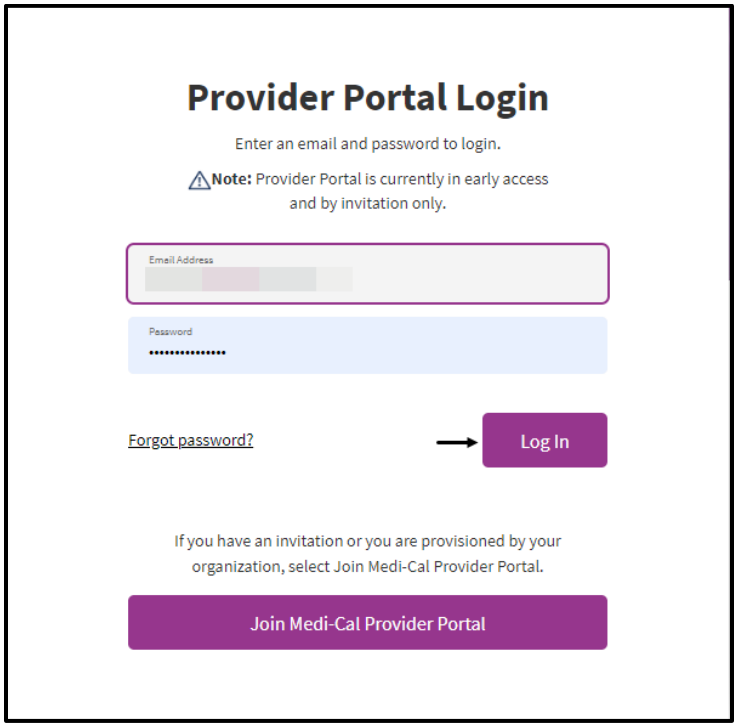


Figure 1.2: Provider Portal Login page.

3. Navigate to the **Transaction Center**.

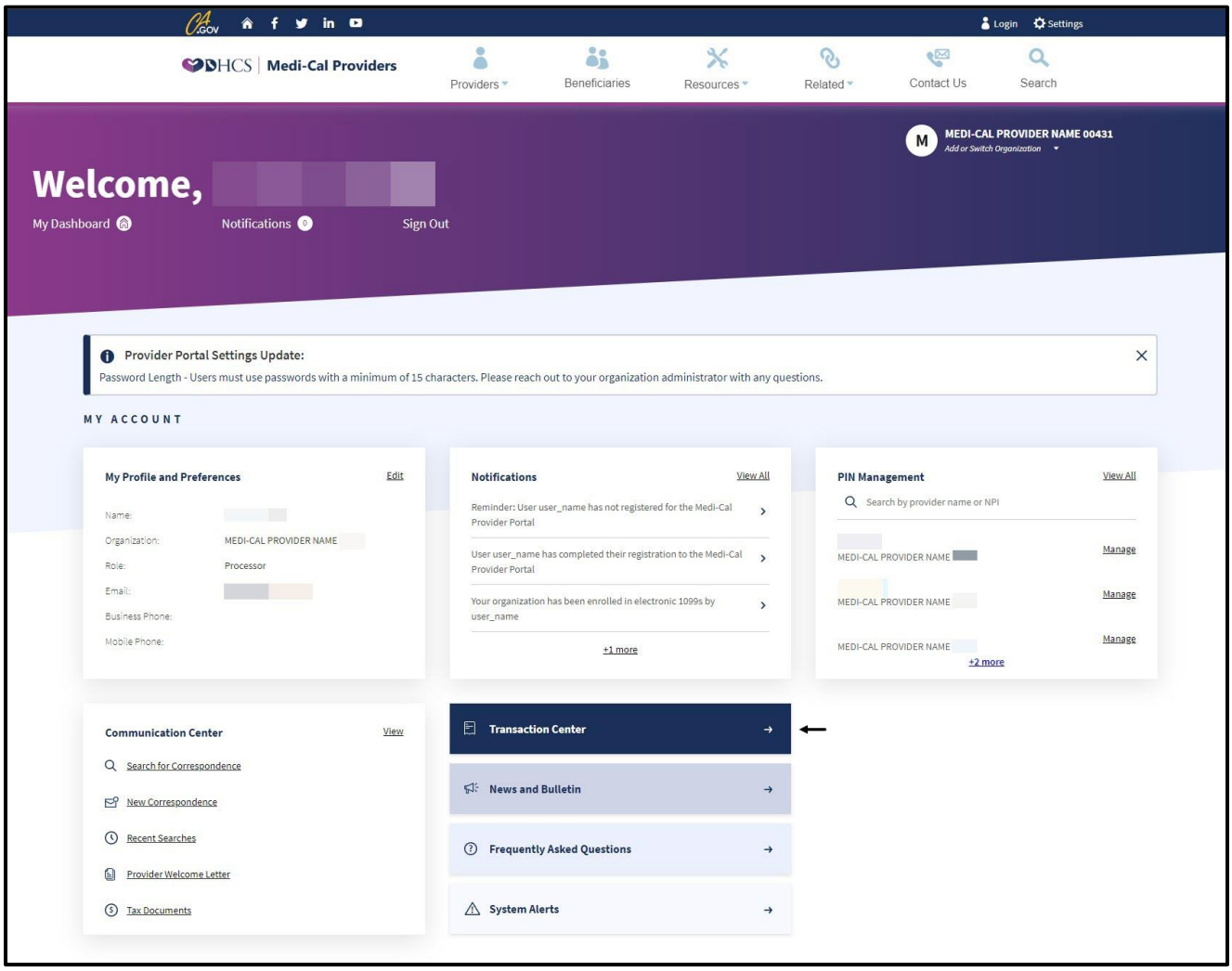


Figure 1.3: Provider Portal homepage.

4. From the drop-down menu, choose the desired National Provider Identifier (NPI) then select **Enter Transaction Services**.

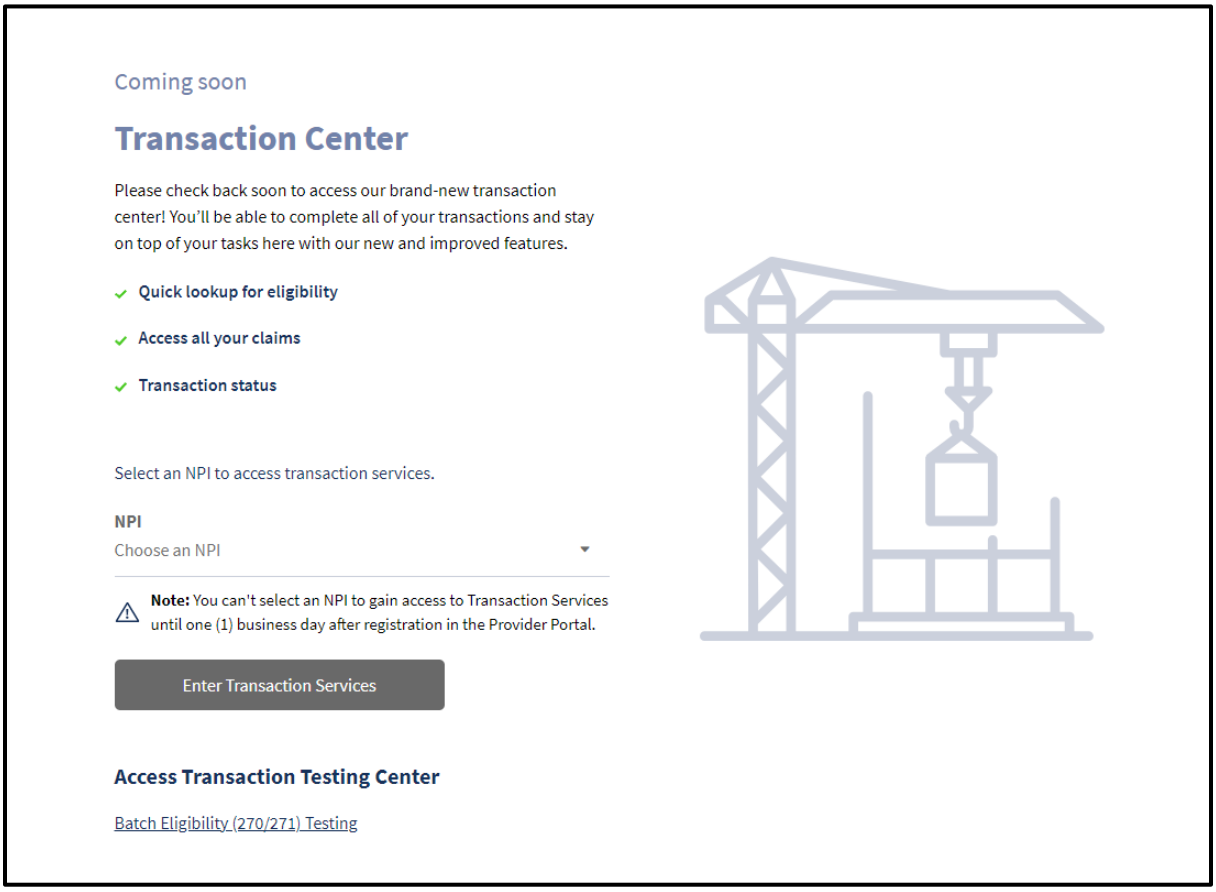


Figure 1.4: Transaction Center page.

5. Under Claims, select **Medical Services Reservation.**

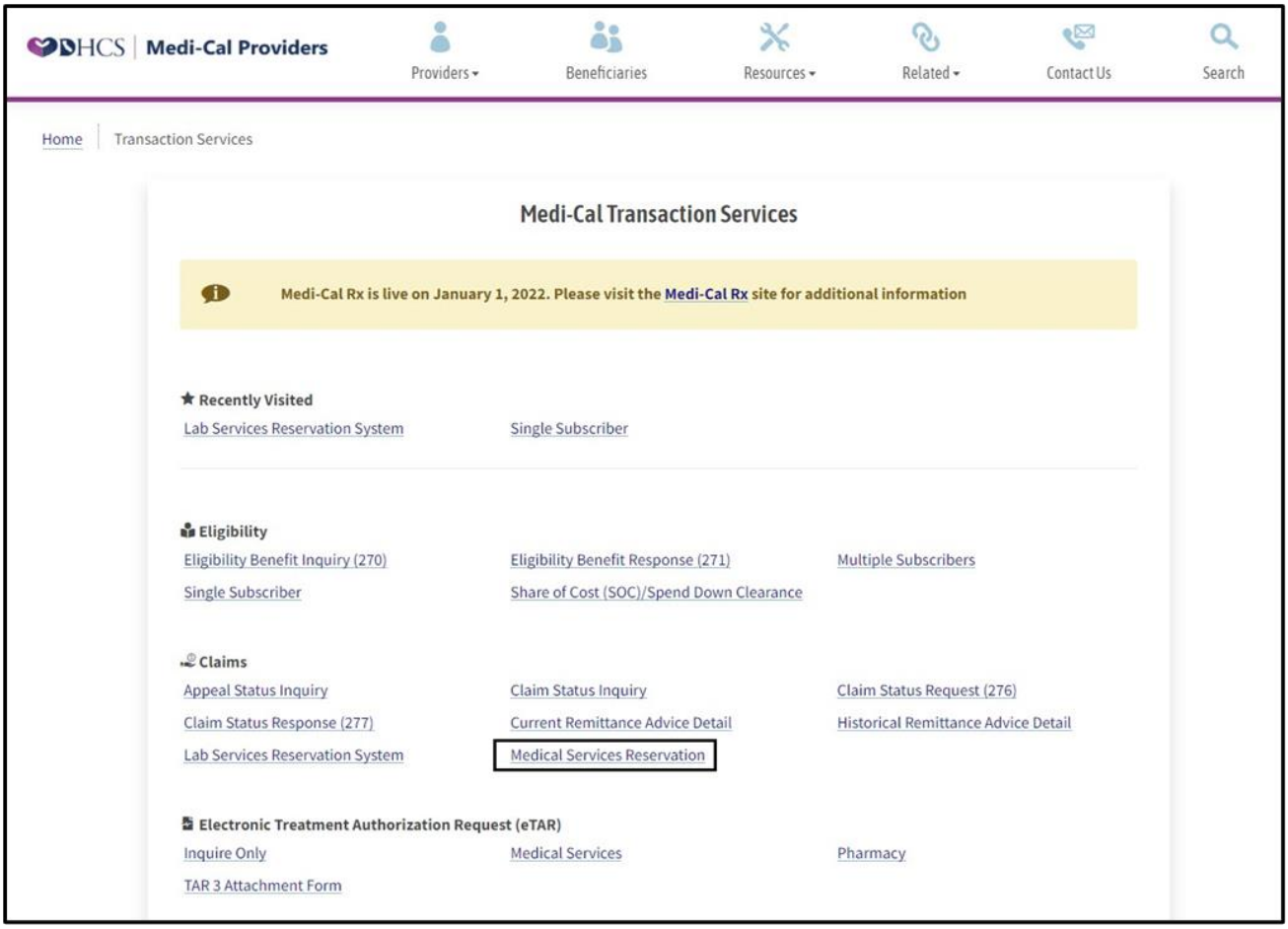


Figure 1.5: Medi-Cal Transaction Services – Medical Services Reservation link.

6. Fill out the reservation form and press **Submit.**

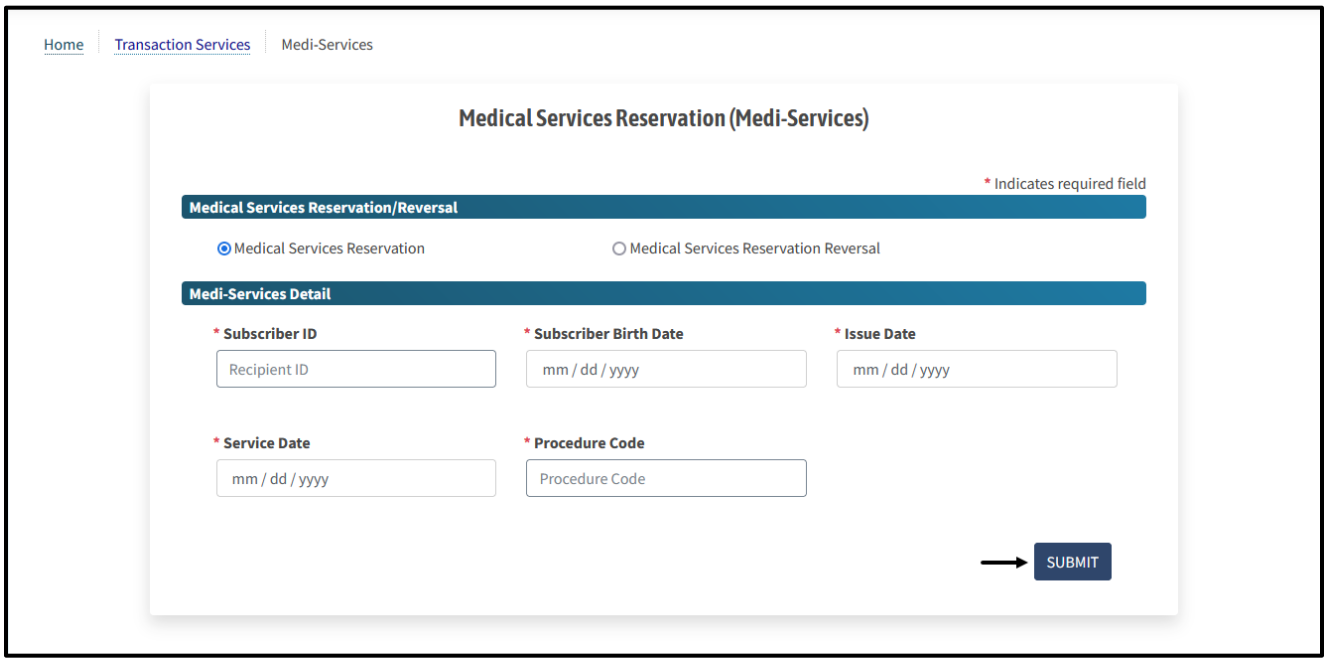


Figure 1.6: Medical Services Reservation (Medi-Services) form.

Lab Services Reservation System (LSRS)

The Lab Services Reservation System (LSRS) is an online system used to schedule beneficiary lab services. To access LSRS log into **Transaction Services**.

1. Under Claims, select **Lab Services Reservation System.**

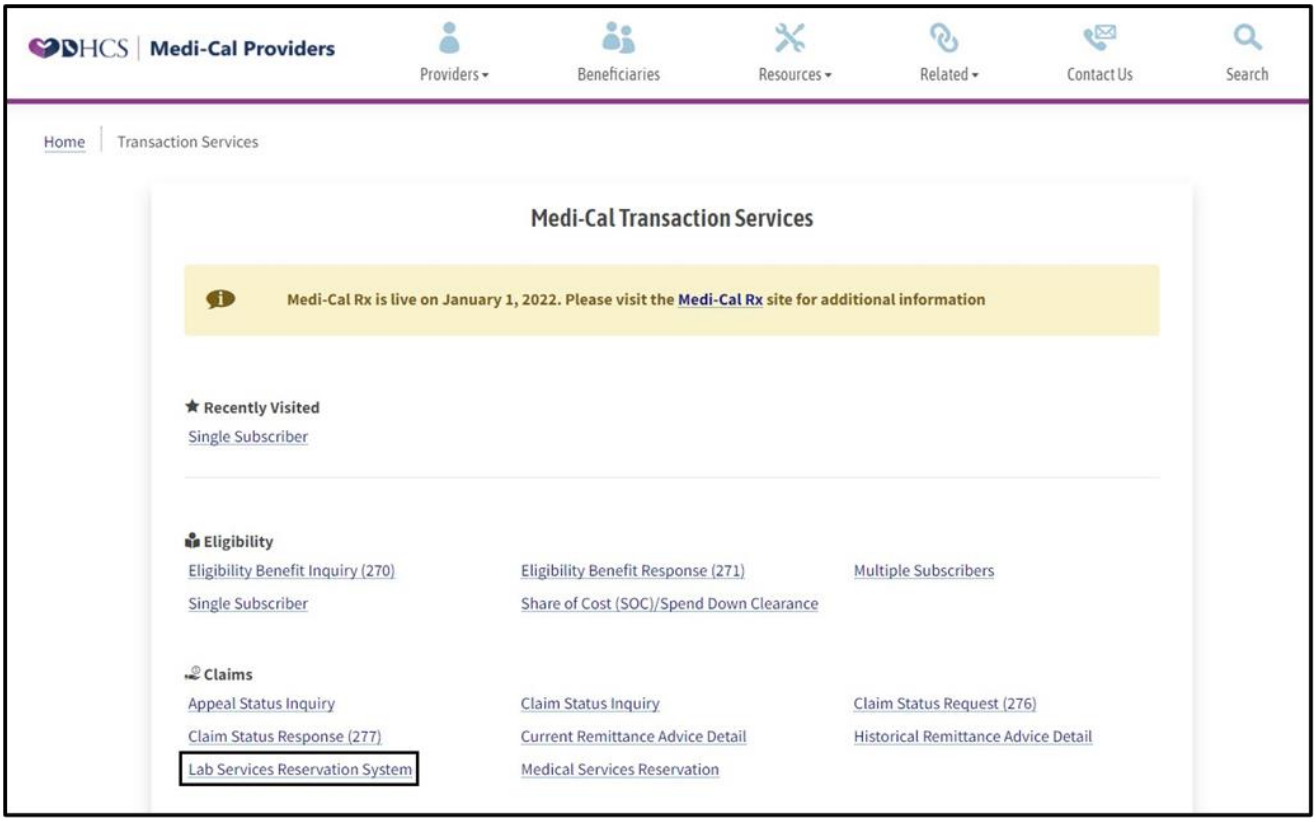


Figure 2.1: Medi-Cal Transactions Services page – Lab Services Reservation System link.

2. Fill out the reservation form and select **Reserve this Service.**

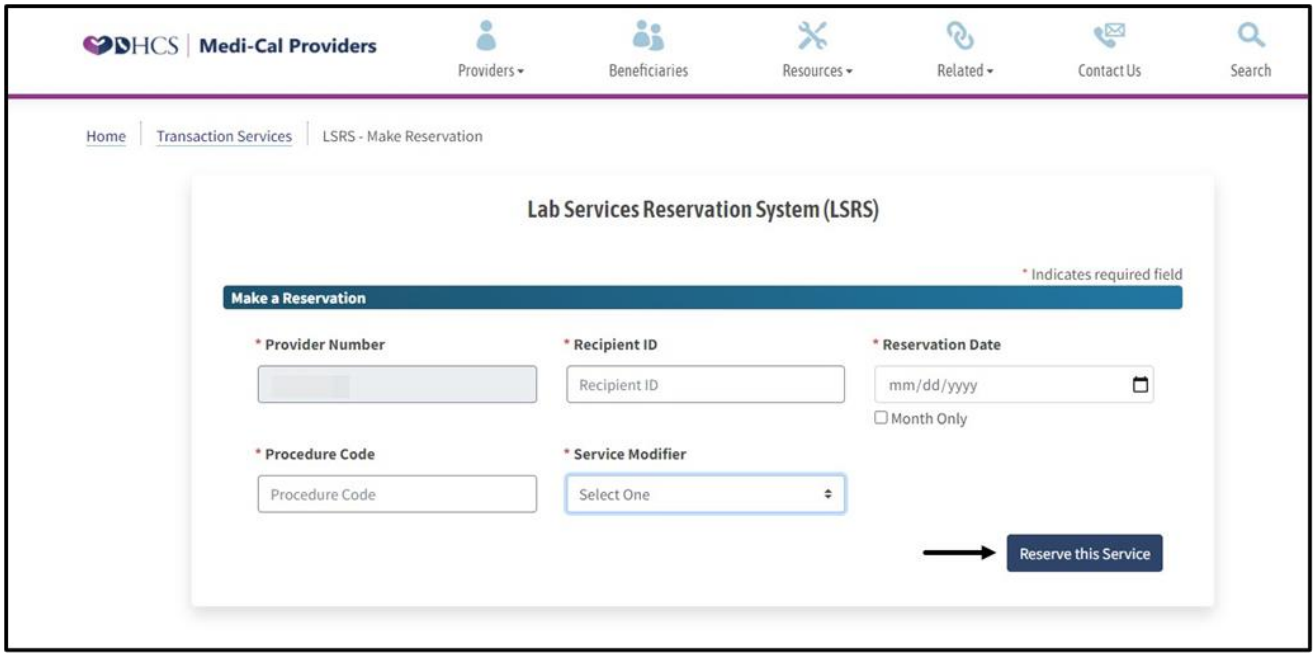


Figure 2.2: Medi Reservation Request Screen.

Knowledge Review 1

1. When a recipient provides their BIC, this means they are Medi-Cal Eligible.
   True ☐ False ☐
2. What can be identified when using the BIC to determine eligibility?
   a. Eligibility
   b. Share of Cost (SOC)
   c. Other Health Coverage (OHC)
   d. Aid Codes
   e. Managed Care Plans (MCPs)
   f. All the above
3. A provider may ask for a second form of ID to help confirm a recipient's identification.
   True ☐ False ☐

See the Appendix for the Answer Key.

POS Network

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

- 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:

- Internet (Medi-Cal Providers website)
- Third Party Software (contact CMC Help Desk at 1-800-541-5555)
- Automated Eligibility Verification System (AEVS) (1-800-456-2387)

Required information for checking recipient eligibility:

- Subscriber ID number
- Subscriber Date of Birth (DOB)
- Issue date
- Date of Service (DOS)

Notes:

_____

_____

_____

_____

_____

_____

_____

Internet Eligibility Verification (Medi-Cal Providers Website) Utilizing Transaction Services

Requirements

- Medi-Cal Provider Identification Number (User ID) and a PIN

Internet Eligibility Verification 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 Providers website

To access the Internet Eligibility Verification, log into **Transaction Services**.

1. From the Medi-Cal Transaction Services menu, select **Single Subscriber.**

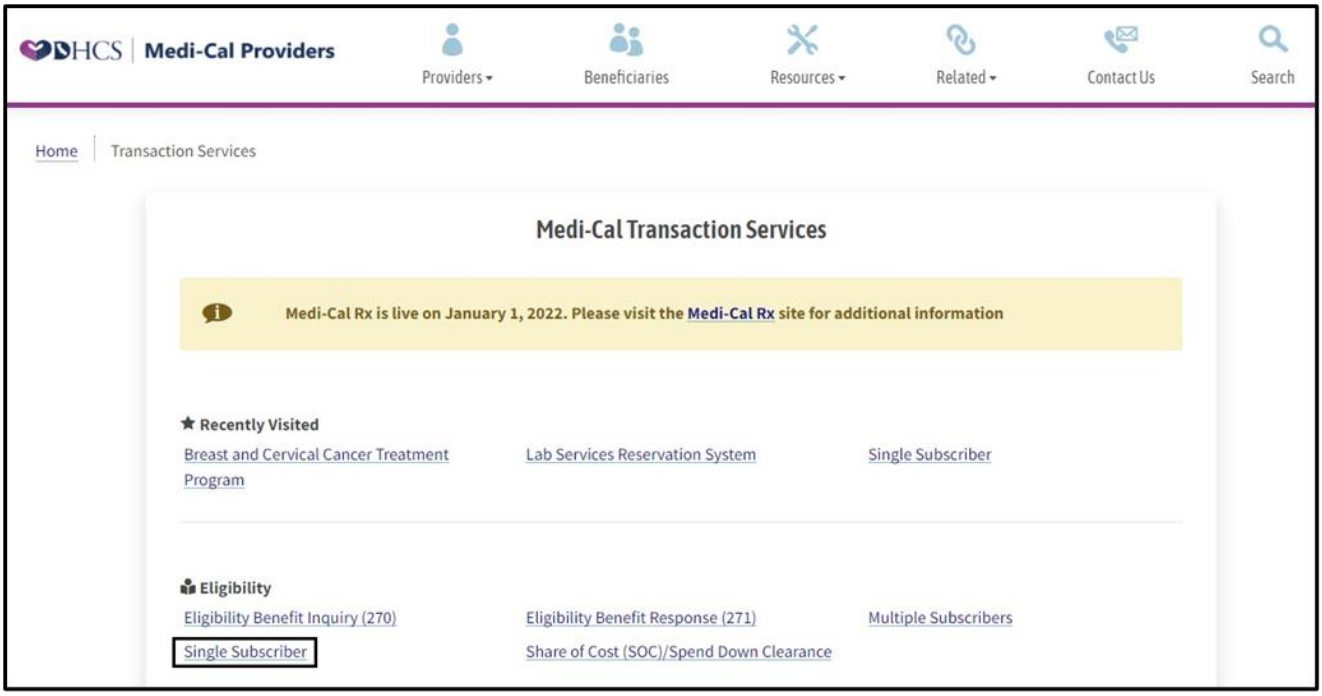


Figure 3.1: Medi-Cal Transaction Services page – Single Subscriber link.

2. Fill out the **Single Subscriber** form and select **Submit.**

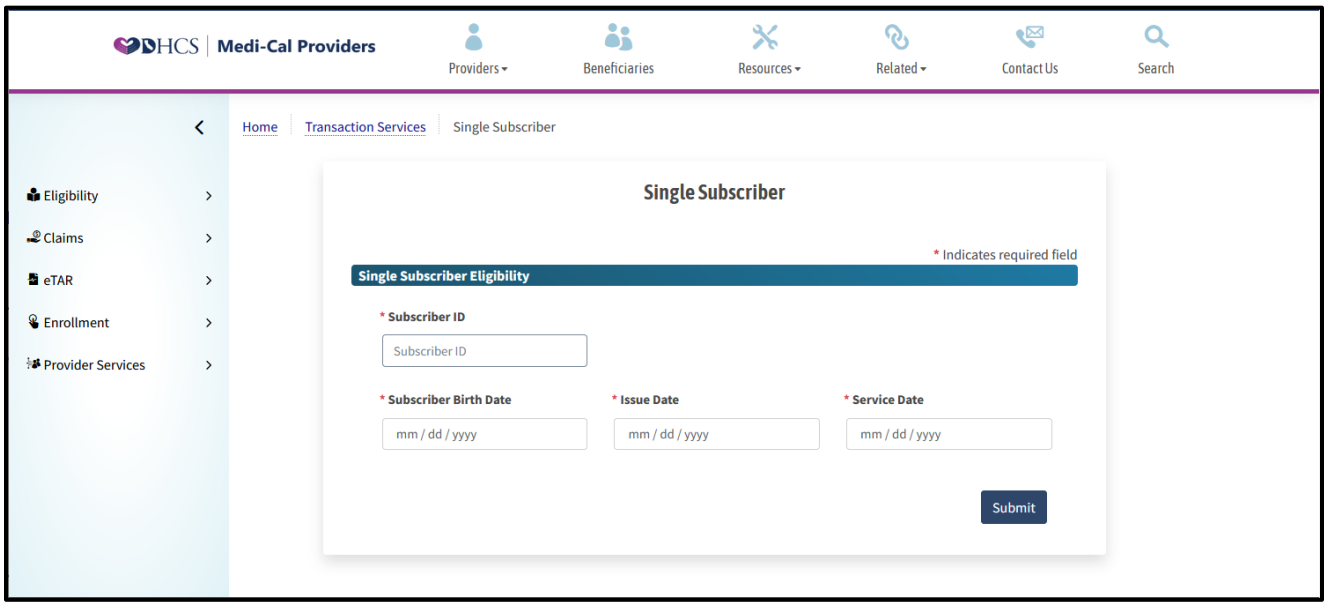


Figure 3.2: Single Subscriber form.

Eligibility Responses

The green banner at the top of the page (with a check mark inside a circle) means eligibility is established, and providers may render services.

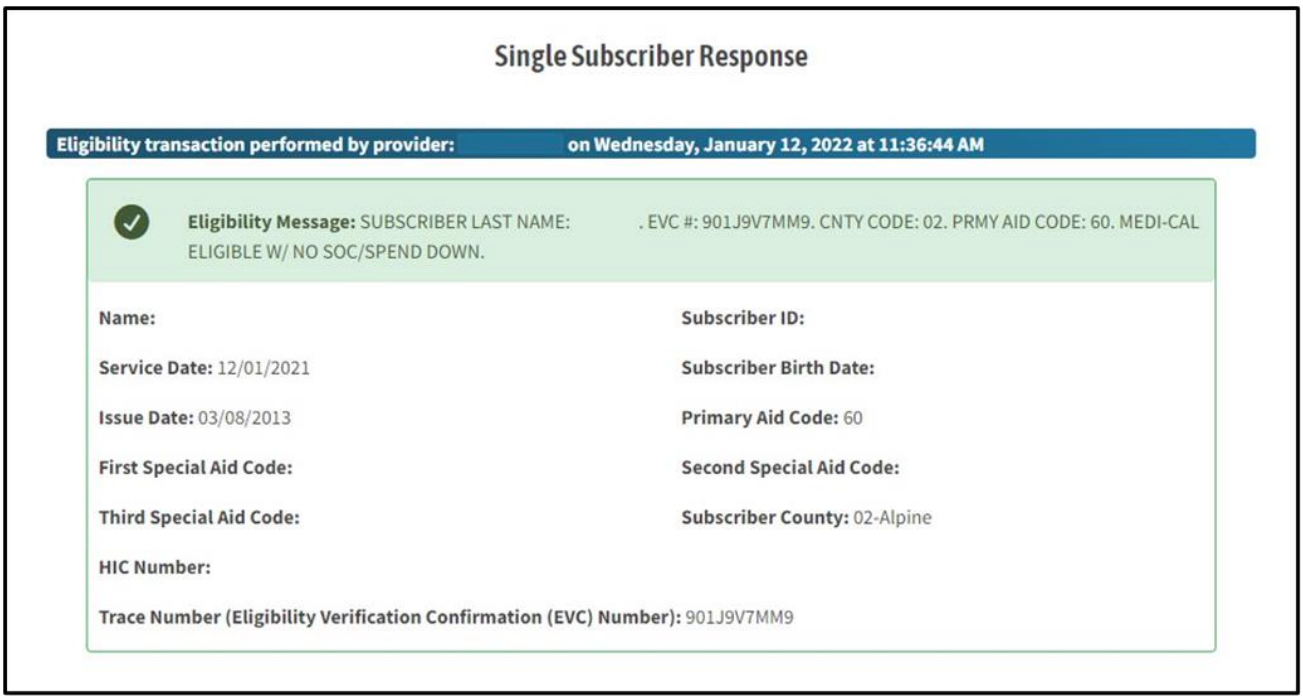


Figure 4.1: Eligibility Message with green banner.

The yellow banner at the top (with an exclamation point [!] inside a triangle) directs providers' attention to special circumstances.

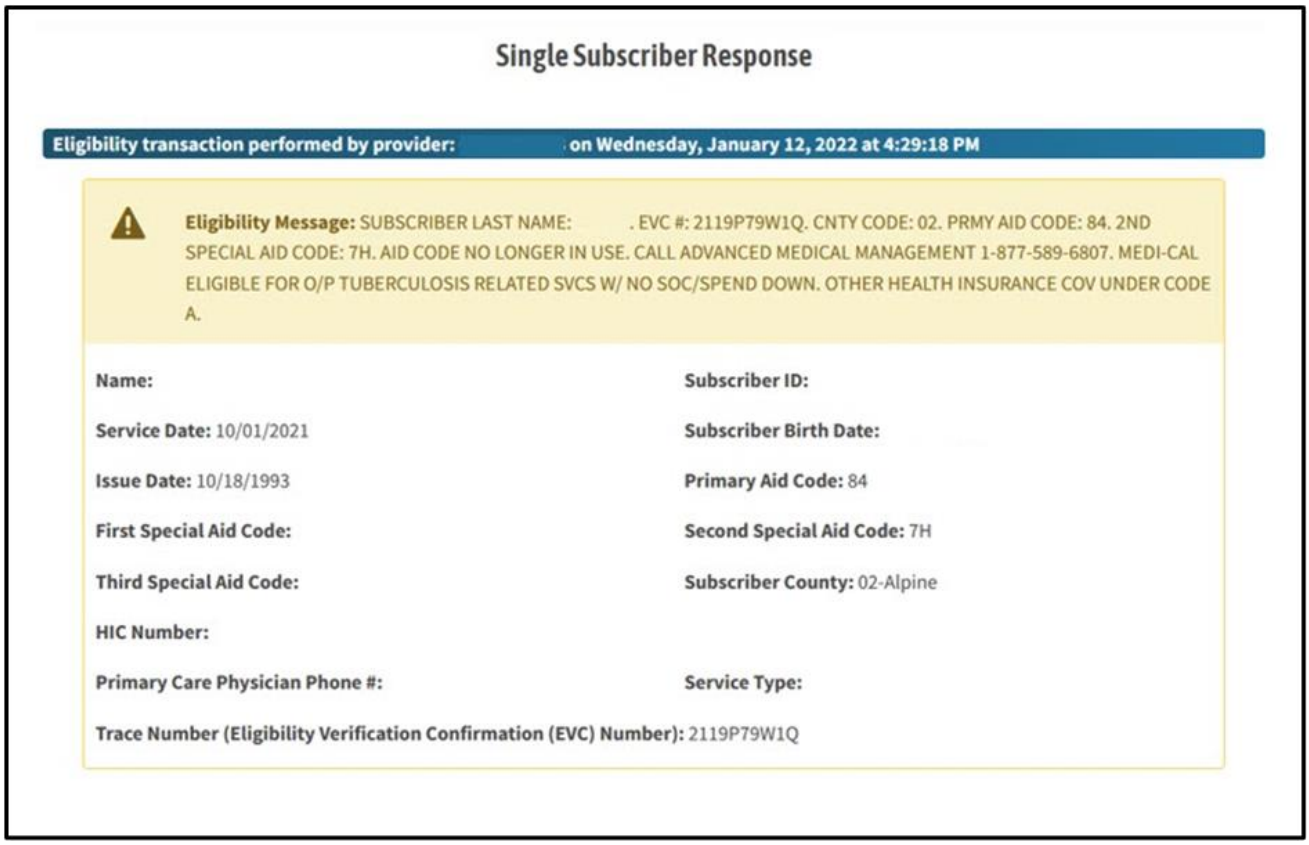


Figure 4.2: Eligibility Message with yellow banner.

The red banner at the top (with a hand inside a hexagon) means no Medi-Cal eligibility.

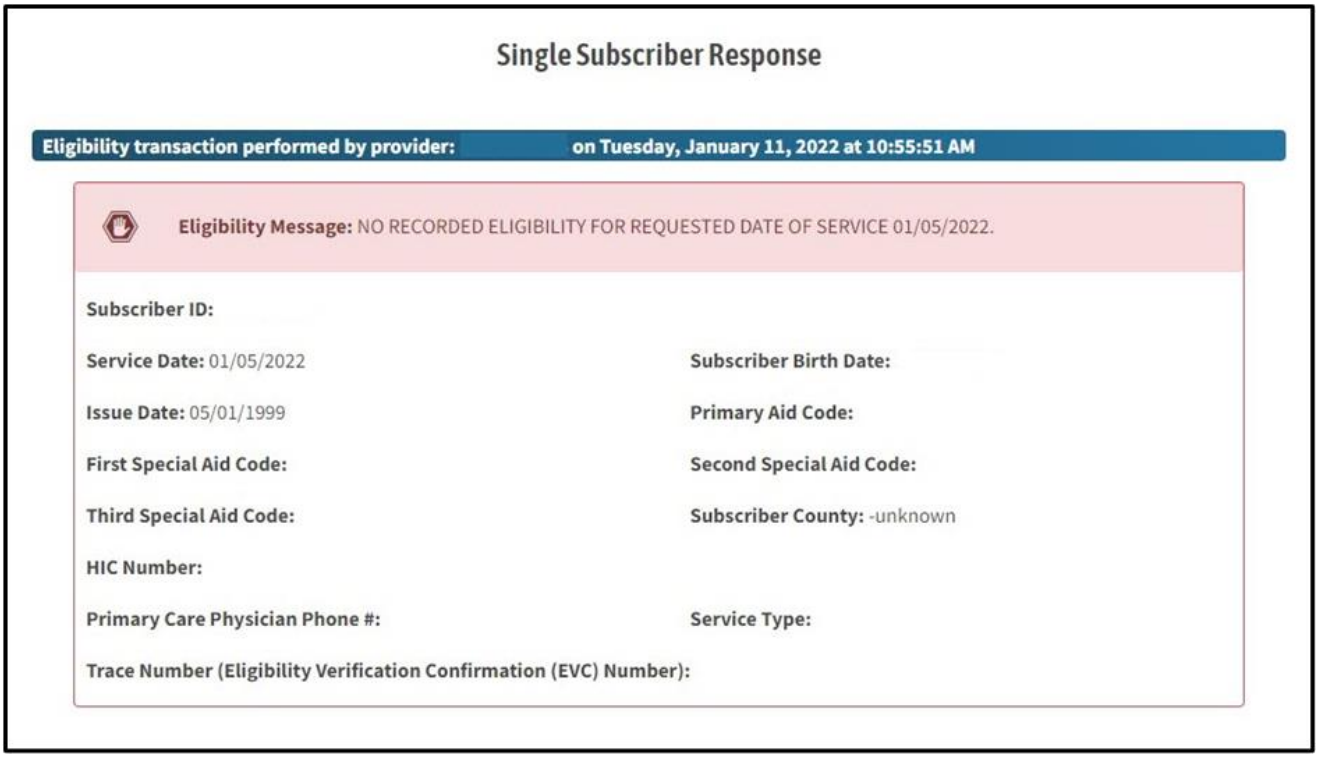


Figure 4.3: Eligibility Message with red banner.

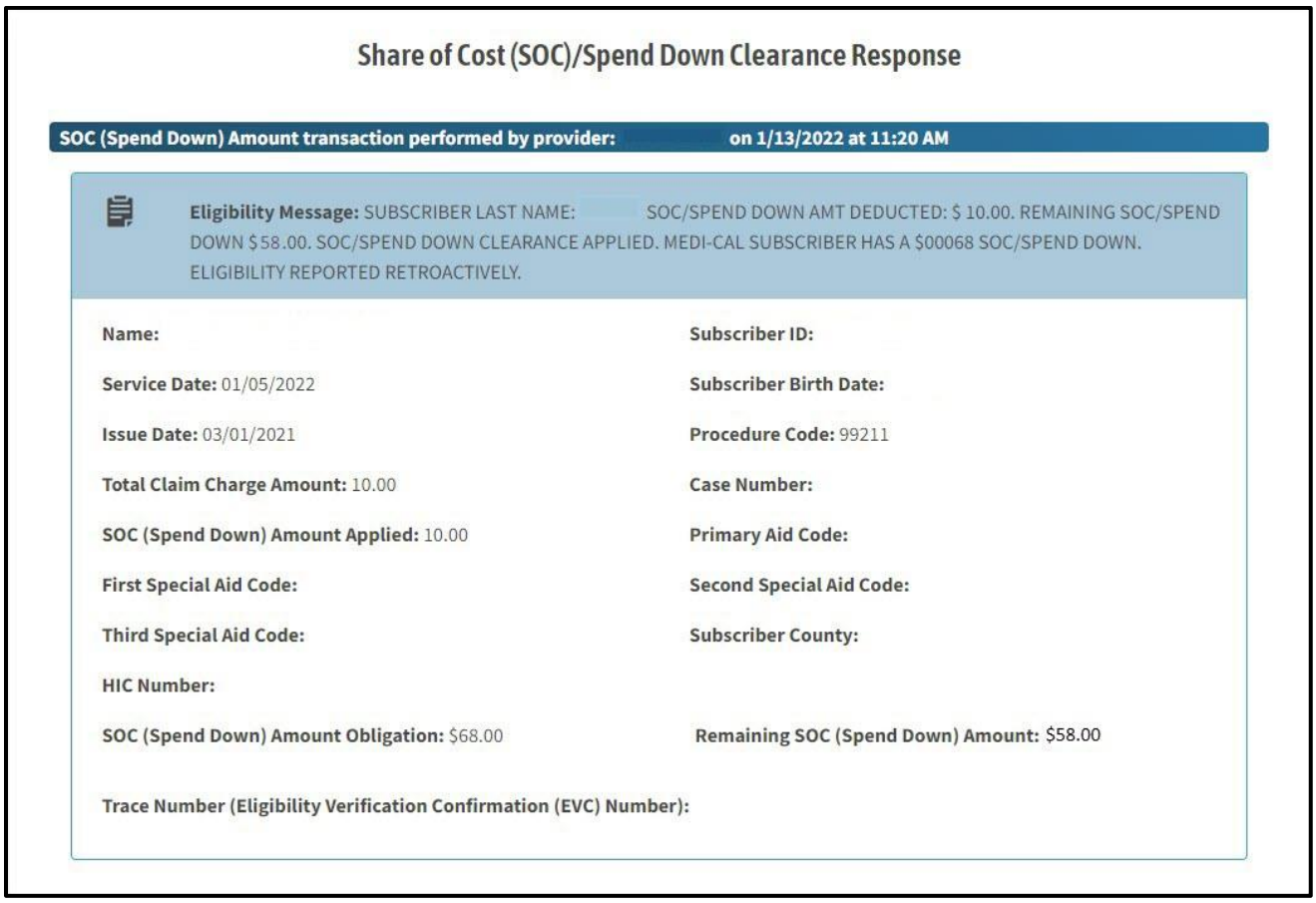


Figure 4.4: Medi-Cal Eligible Recipient with a SOC (Share of Cost).

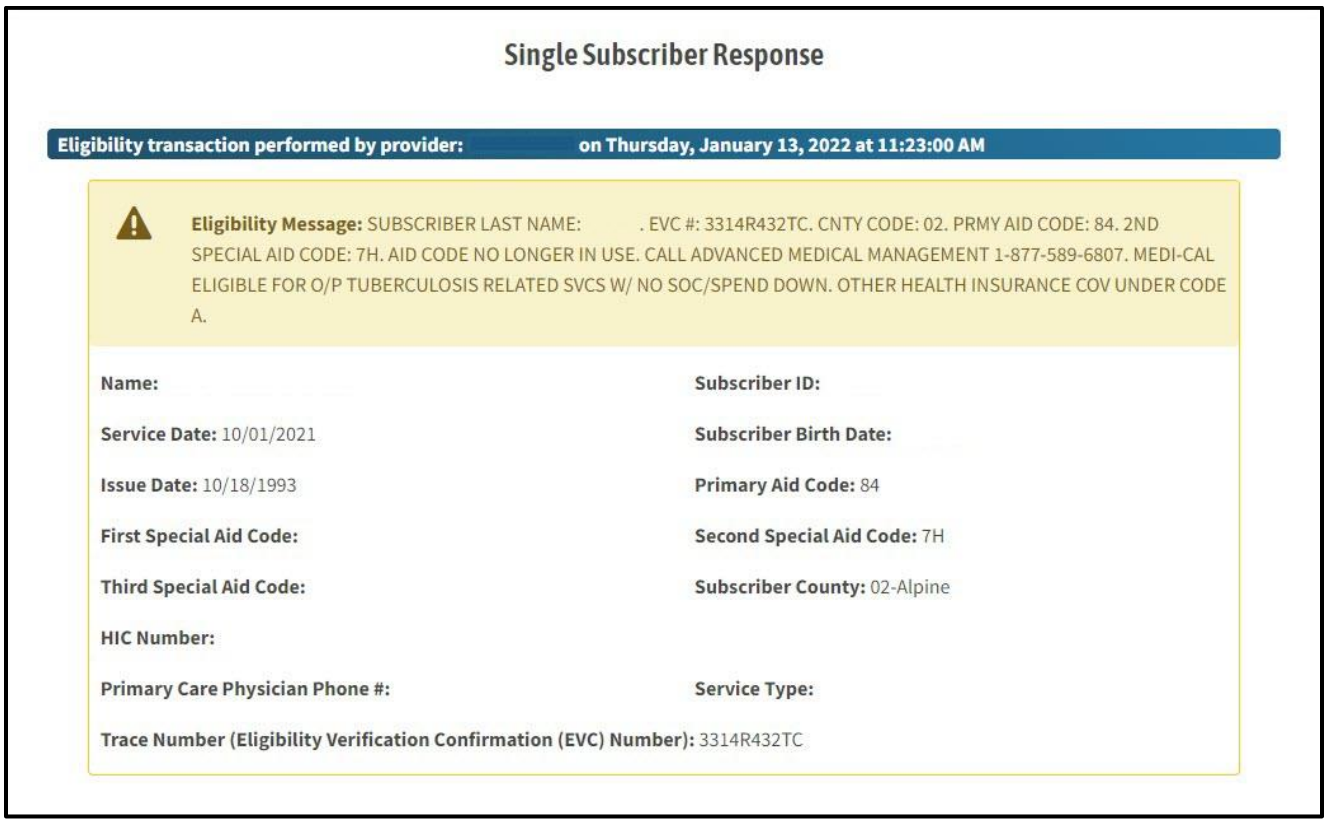


Figure 4.5: Medi-Cal Eligible Recipient with OHC (Other Health Coverage).

Knowledge Review 2

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

1. _____
2. _____
3. _____

See the Appendix for the Answer Key.

Notes:

_____

_____

_____

_____

_____

_____

_____

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)

The Automated Eligibility Verification System (AEVS) is an interactive voice response system that allows providers to access recipient eligibility, clear Share of Cost (SOC) liability and/or reserve Medi-Services. There is no enrollment requirement to participate in AEVS. Providers must use a valid Provider Identification Number (PIN) to access AEVS. The PIN is issued when providers enroll with Medi-Cal.

AEVS verifies a recipient's eligibility of the current and/or prior 12 months; provides information on SOC, Other Health Coverage (OHC) and Prepaid Health plan (PHP) status; identifies recipients in fee-for-service pending enrollment into a Medi-Cal managed care plan, a Denti-Cal managed care plan or both; identifies any service restrictions, SOC liability and allows podiatrists and certain Allied Health providers to reserve Medi-Services.

Notes:

A Recipient Eligibility

Page updated: January 2022

AEVS accesses the most current recipient information for a specific month of eligibility. AEVS returns a 10-character Eligibility Verification Confirmation (EVC) number, after eligibility is confirmed.

Features

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

Limitations

Limited to 10 inquiries per call

Notes:

Automated Eligibility Verification System (AEVS) Response

Automated Eligibility Verification System (AEVS) Response Log

Transaction Type:

__ Eligibility Verification

__ Share of Cost (SOC)
__ spend down
__ reversal

__ Medi-Service
__ reservation
__ reversal

Information Entered:

Beneficiary ID #: _____ Date of Birth: _____ (mm/yyyy) Date of Service: _____ (mm/yyyy)

Procedure Code: _____ (SOC or Medi-Service)

Billed Amount: $_____ (SOC only)

Applied Amount: $_____ (Multiple SOC Cases only) SOC Case #: _____
Applied Amount: $_____ (Multiple SOC Cases only) SOC Case #: _____
Applied Amount: $_____ (Multiple SOC Cases only) SOC Case #: _____

Response from the Network:

Beneficiary Name: _____ County Code: _____

Primary Aid Code: _____
1st Special Aid Code: _____
2nd Special Aid Code: _____

Message(s): _____

_____

_____

Share of Cost (if any): $_____

Case #: _____ SOC: $_____
Case #: _____ SOC: $_____
Case #: _____ SOC: $_____

Medicare Coverage: ___ Part A ___ Part B HIC #: _____

Other Health Insurance Coverage code: _____

Scope of Coverage (circle those which apply): *V P L O I M COMPREHENSIVE*

Eligibility Verification Confirmation Number: _____

Today's Date: _____ Transaction performed by: _____

(THIS FORM IS FOR YOUR RECORDS ONLY)

1 – AEVS: Transactions
ProPubs

February 2015

When requesting eligibility verification for a recipient with OHC, the Medi-Cal eligibility verification system returns a message stating a recipient's Scope of Coverage (COV). COV codes designate the specific service categories covered by a recipient's health coverage.

The **Code Explanation** "OIMVLP" explanation means a recipient's insurance covers inpatient, outpatient, medical, vision, long term care and prescription drugs/medical supplies. These are the COV codes and each recipient's plan differs. Each COV code indicates a different set of services. Refer to the COV code chart below or the *Other Health Coverage (OHC) Guidelines for Billing* (other guide) section of the Part 1 provider manual.

Table of Scope of Coverage (COV) Codes

COV Code	Service Category
P	Prescription Drugs/Medical Supplies
L	Long Term Care
I	Hospital Inpatient
O	Hospital Outpatient
M	Medical and Allied Services
V	Vision Care Services
R	Medicare Part D
D	Dental Services

Note: The combination of OHC and COV codes helps providers determine when to bill OHC before billing Medi-Cal.

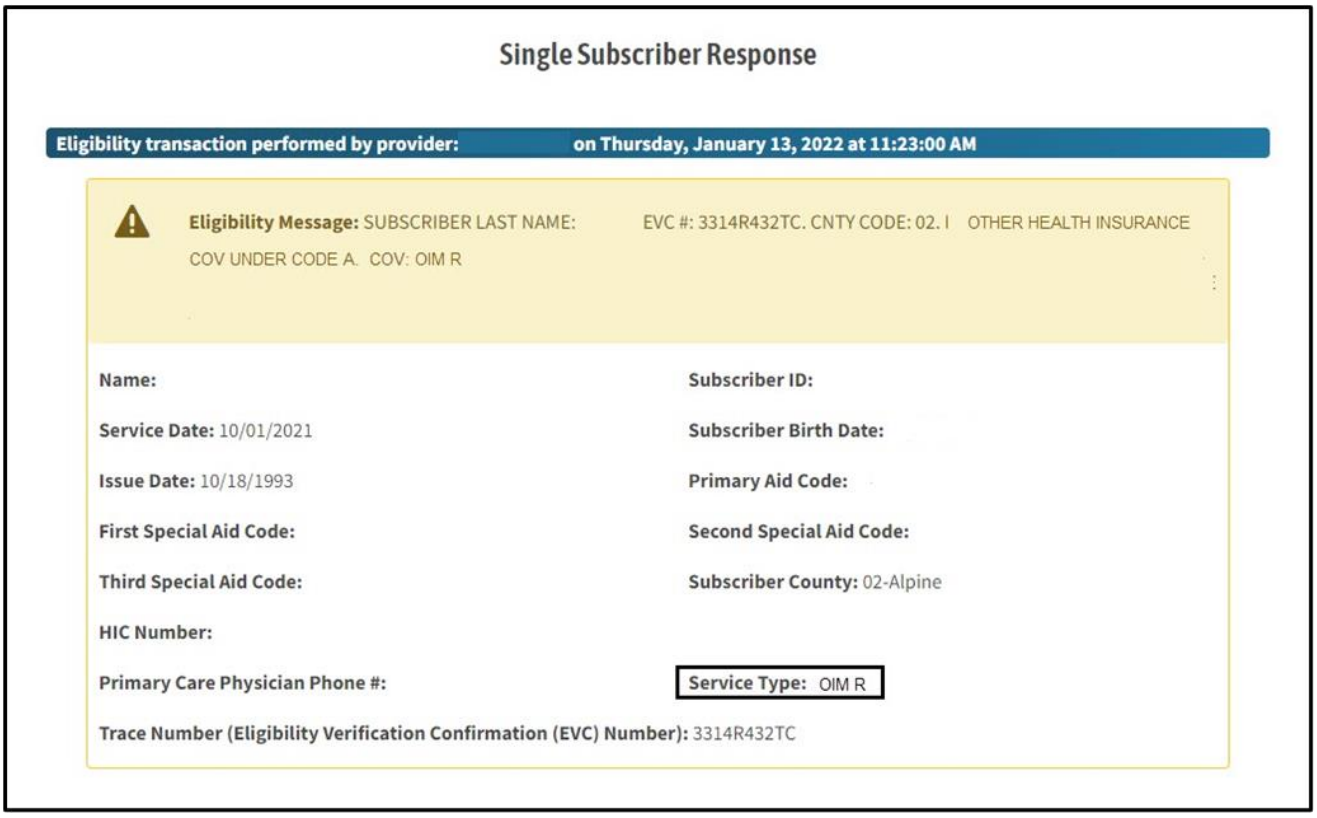


Figure 5.1: Medi-Cal eligible recipient showing the COV codes covered

Resource Information

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)
Hospital Presumptive Eligibility (HPE) Program Process (hospital presum)
Presumptive Eligibility for Pregnant Women Program Process (presum proc)
Presumptive Eligibility for Pregnant Women (presum)

Specialty Program

EPSDT/CHDP: Gateway Transactions (epsdt chdp gate)

Other References

Internet user guide

Child Health and Disability Prevention (CHDP) Gateway Internet Step-by-Step User Guide

Presumptive Eligibility for Pregnant Women (PE4PW) Application Web Portal User Guide

Hospital Presumptive Eligibility (HPE) Application Web Portal User Guide

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

Acronyms

A list of current acronyms is in the *Appendix* section of each complete 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

Recipient Eligibility Verification

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

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

Eligibility Verification via the Medi-Cal Provider Website

Requirements

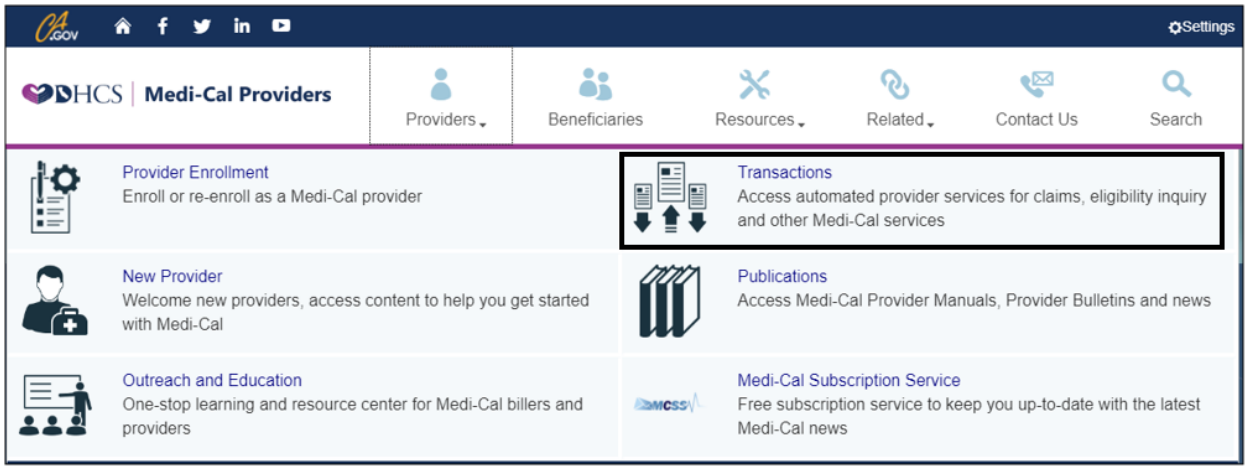
- Medi-Cal POS Network/Internet Agreement form
- Medi-Cal Provider Identification Number (User ID) and a PIN

B Share of Cost (SOC)

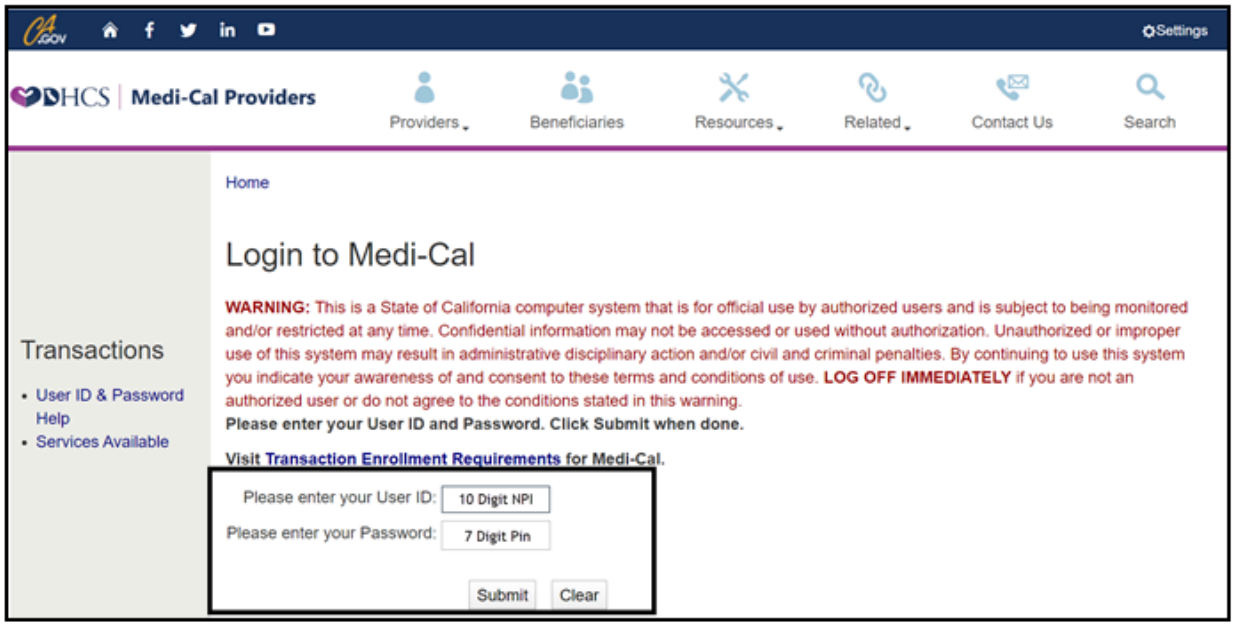
Page updated: September 2020

To log into the Internet Eligibility Verification, go to the Medi-Cal Provider website (www.medi-cal.ca.gov).

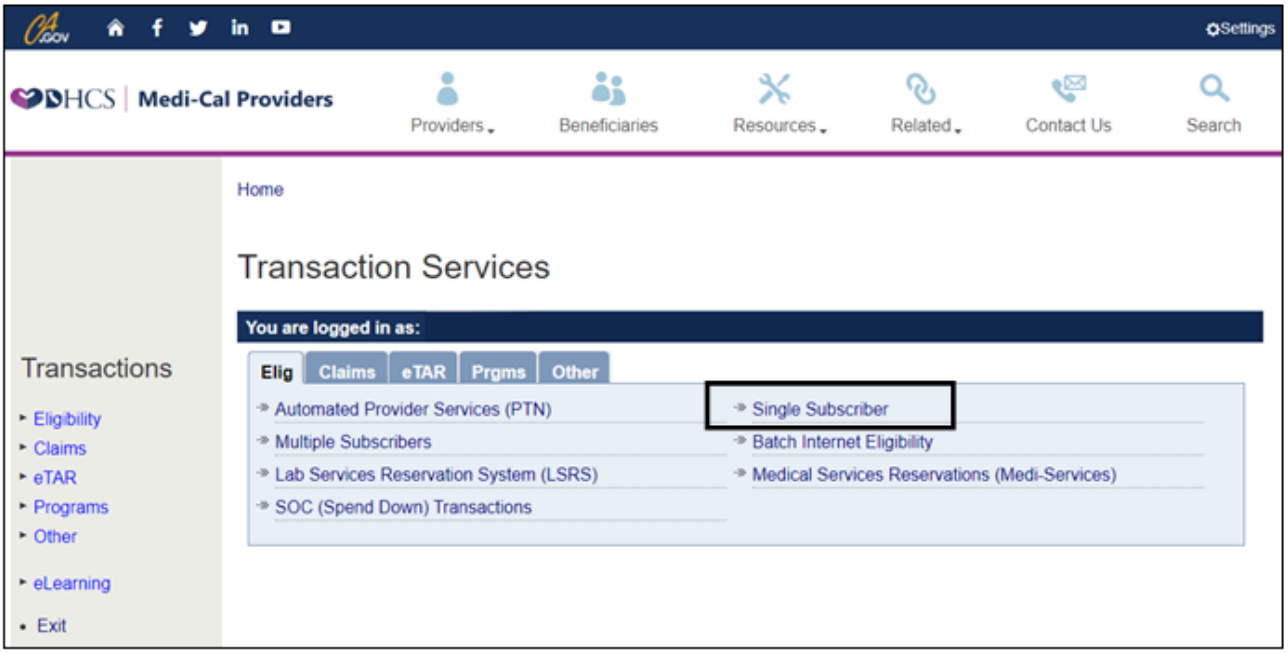
1. From the **Provider** drop-down menu, select **Transactions**



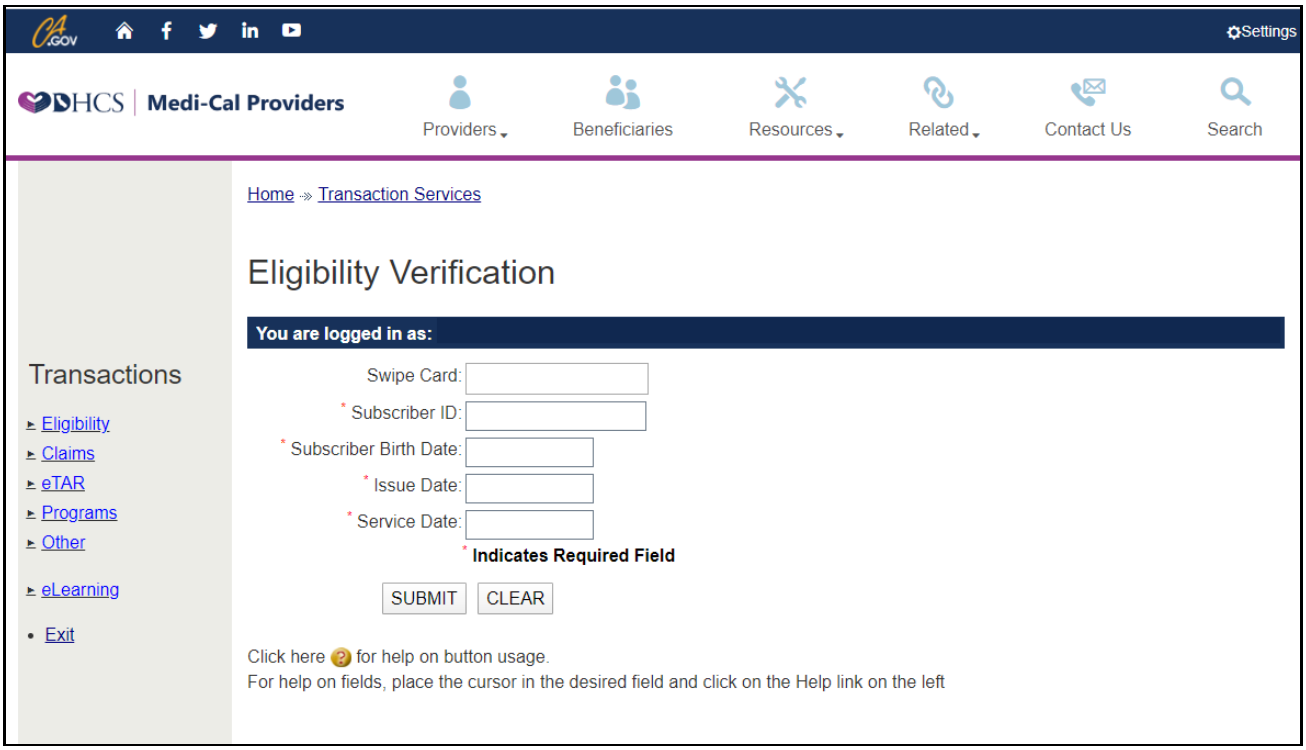
2. Login into **Transactions** with your **User ID** and **Password**



3. Select **Single Subscriber**



4. Fill out **Eligibility Verification** form and click **Submit**



Example: Transaction Services SOC message

Name:		
Subscriber ID:		
Service Date: 10/01/2019	Subscriber Birth Date:	Issue Date:
Procedure Code:		
Total Claim Charge Amount:	Case Number:	SOC (Spend Down) Amount Applied:
Primary Aid Code: 48	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 34 - Sacramento	HIC Number:	
Trace Number (Eligibility Verification Confirmation (EVC) Number):		
Eligibility Message: SUBSCRIBER LAST NAME: CNTY CODE: 34, PRIMARY AID CODE:48, MEDI-CAL ELIGIBLE FOR PREGNANCY/ POSTPARTUM RELATED MEDICAL SVCS W/NO SOC FOR ALL OTHER MEDI-CAL SVCS, RECIPT. HAS SOC OF $ 50.00. REMAINING SOC $ 50.00		

Knowledge Review 1

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

See the Appendix for the Answer Key.

Notes:

SOC Certification

Recipients are not eligible to receive Medi-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 is 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

An 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 a SOC.

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

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. Once the SOC has been cleared, providers can no longer conduct a reversal.

Notes:

Knowledge Review 2

1. Generally, a recipient's SOC is determined by the county Department of Social Services (or welfare) 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 ☐

See the Appendix for the Answer Key.

Notes:

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.

Providers who are submitting 837I (institutional) transactions in the 5010 format should use the HI value information segment in loop 2300 of the 005010X223A2 with a qualifier of BE and value code of FC to report SOC information. Many providers are reporting that the SOC is not being deducted from 837I claims, and this is due to the way the information is being submitted. Please refer to the CMC Billing and Technical Manual for more information regarding submitting electronic claims

Example: Transaction Service message indicating recipient has an LTC SOC

Name:		
Subscriber ID:		
Service Date: 10/01/2018	Subscriber Birth Date:	Issue Date:
Primary Aid Code: 13	First Special Aid Code:	
Second Special Aid Code:	Third Special Aid Code:	
Subscriber County: 34 - Sacramento	HIC Number:	
Primary Care Physician Phone #:	Service Type: R	
Spend Down Amount Obligation: $1,165.00	Remaining Spend Down Amount:	
Trace Number (Eligibility Verification Confirmation (EVC) Number):		
Eligibility Message: SUBSCRIBER LAST NAME: CNTY CODE: 34, PRIMARY AID CODE: 13, MEDI-CAL ELIBIGLE W/LTC SOC/SPEND DOWN OF $01165, PART A,B AND D MEDICARE COV W/HIC, MEDICARE PART A AND B COVERED SVCS MUST BE BILLED TO MEDICARE BEFORE BILLING MEDI-CAL, MEDICARE PART D COVERED DRUGS MUST BE BILLED TO THE PART D CARRIER BEFORE BILLING MEDI-CAL. CARRIER NAME.		

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 0658), 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 the 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.

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.

Example: Partial Eligibility message for recipient with multiple eligibility

SUBSCRIBER LAST NAME: DIAZ, CNTY CODE: 34, PRIMARY AID CODE: 48, MEDI-CAL ELIGIBLE FOR PREGNANCY/POSTPARTUM RELATED MEDICAL SVCS W/NO SOC.FOR ALL OTHER MEDI-CAL SVCS, RECIPT. HAS SOC OF $50.00. REMAINING SOC $ 50.00

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.

Knowledge Review 3

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

See the Appendix for the Answer Key.

Notes:

_____

_____

_____

_____

_____

_____

_____

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 the cases for which the recipient may clear a 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 SOCs 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.

Notes:

Knowledge Review 4

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?

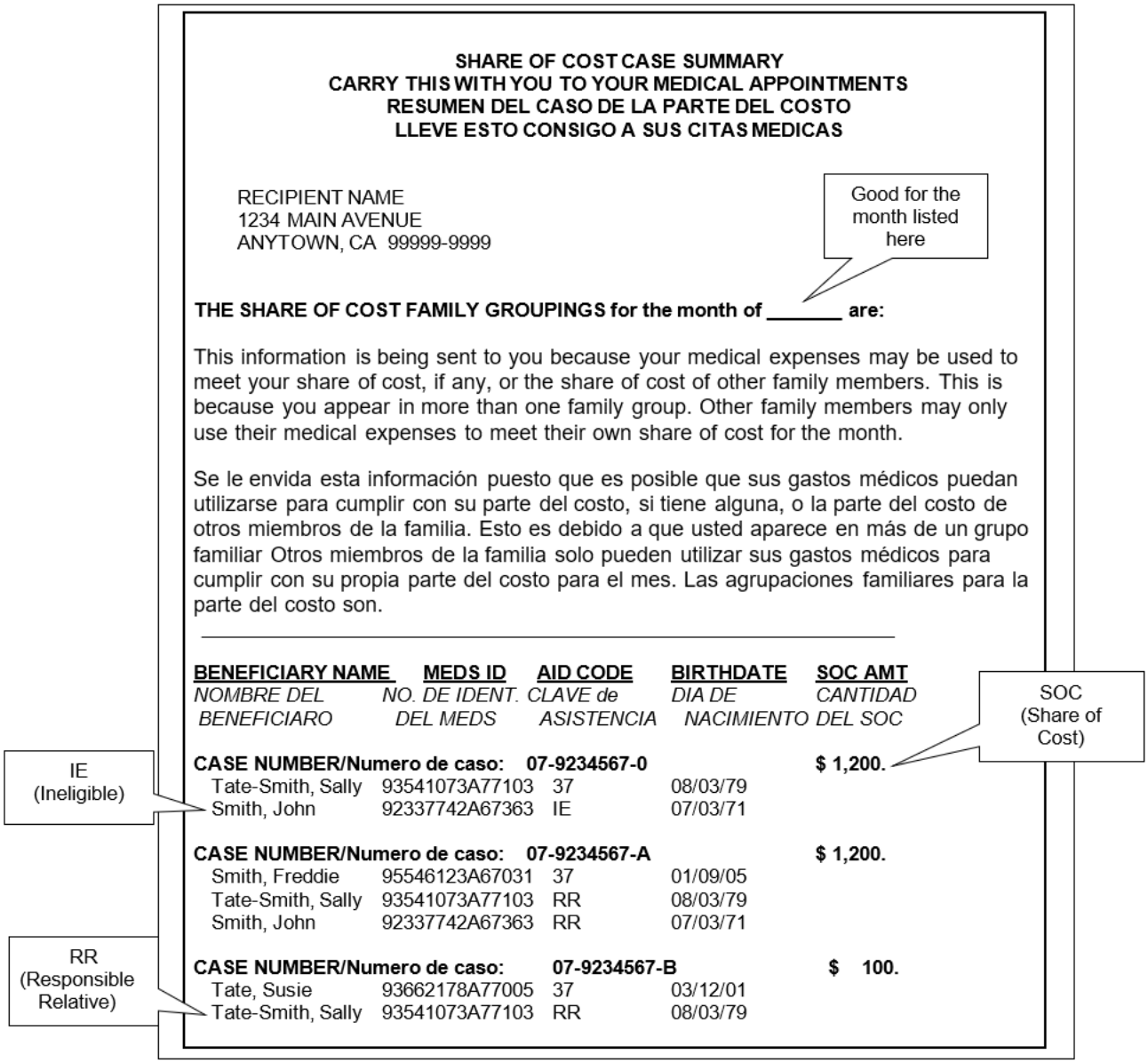
   Yes ☐ No ☐

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 ☐

See the Appendix for the Answer Key.

Notes:



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 envida esta información puesto que es posible que sus gastos médicos 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 más de un grupo familiar Otros miembros de la familia solo pueden utilizar sus gastos médicos para cumplir con su propia parte del costo para el mes. Las agrupaciones familiares para la parte del costo son.

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

SOC (Share of Cost)

IE (Ineligible)

RR (Responsible Relative)

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

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 bills 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:

_____

_____

_____

_____

_____

_____

_____

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:

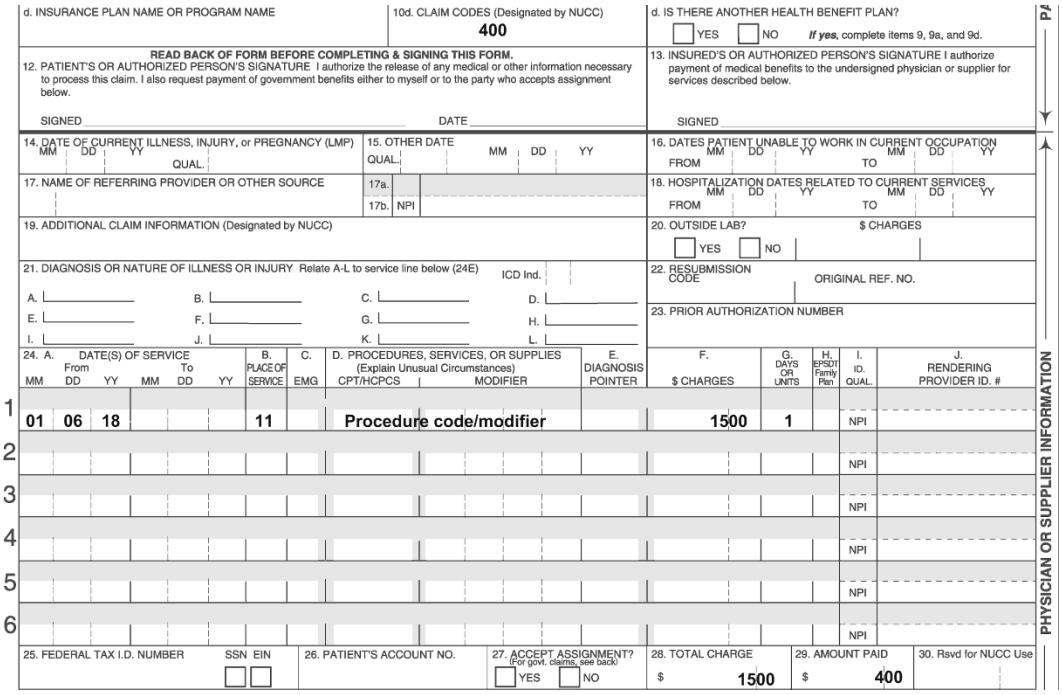
- *Claim Codes* (Box 10d)
- *Amount Paid* (Box 29)

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.

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



d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. CLAIM CODES (Designated by NUCC): 400 | d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

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 MM DD YY FROM ____ TO ____

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE | 17a. | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM ____ TO ____

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. ____ 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	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 06 18		11		Procedure code/modifier		1500	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐ | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO | 28. TOTAL CHARGE $ 1500 | 29. AMOUNT PAID $ 400 | 30. Rsvd for NUCC Use

Payment Request for LTC (25-1) Claim Form

The following information provides guidelines for entering SOC quantities on the *Payment Request for LTC* (25-1) form.

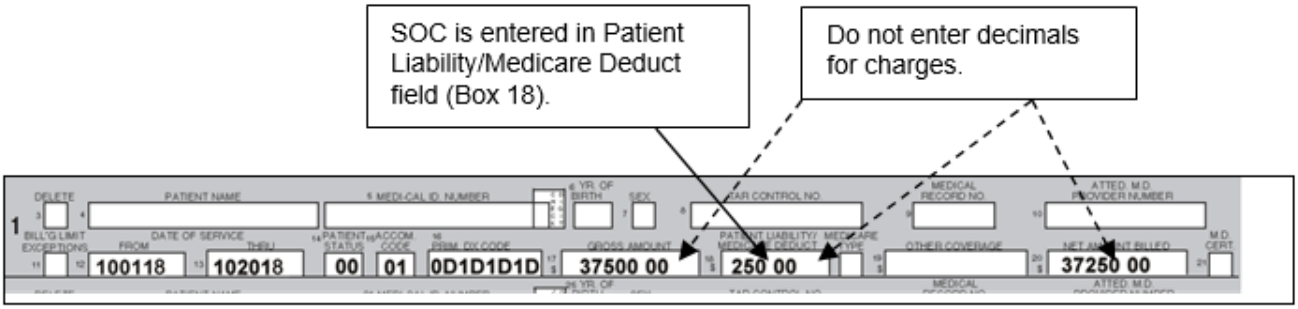
Form Fields

SOC amounts are entered in these fields: Boxes 18, 37, 56, 75, 94 or 113
(*Patient Liability/Medicare Deduct* field)

Instructions

If the SOC for a straight Medi-Cal claim is zero, enter 000 in this field. Do not leave it blank.

Partial Example: SOC amount in *Patient Liability/Medicare Deduct* field (Box 18)



Notes:

UB-04 Claim Form

The following information provides guidelines for entering SOC quantities on the *UB-04* claim form.

Form Fields

SOC amounts are entered in these fields:

- *Value Codes Amount* (Boxes 39-41)

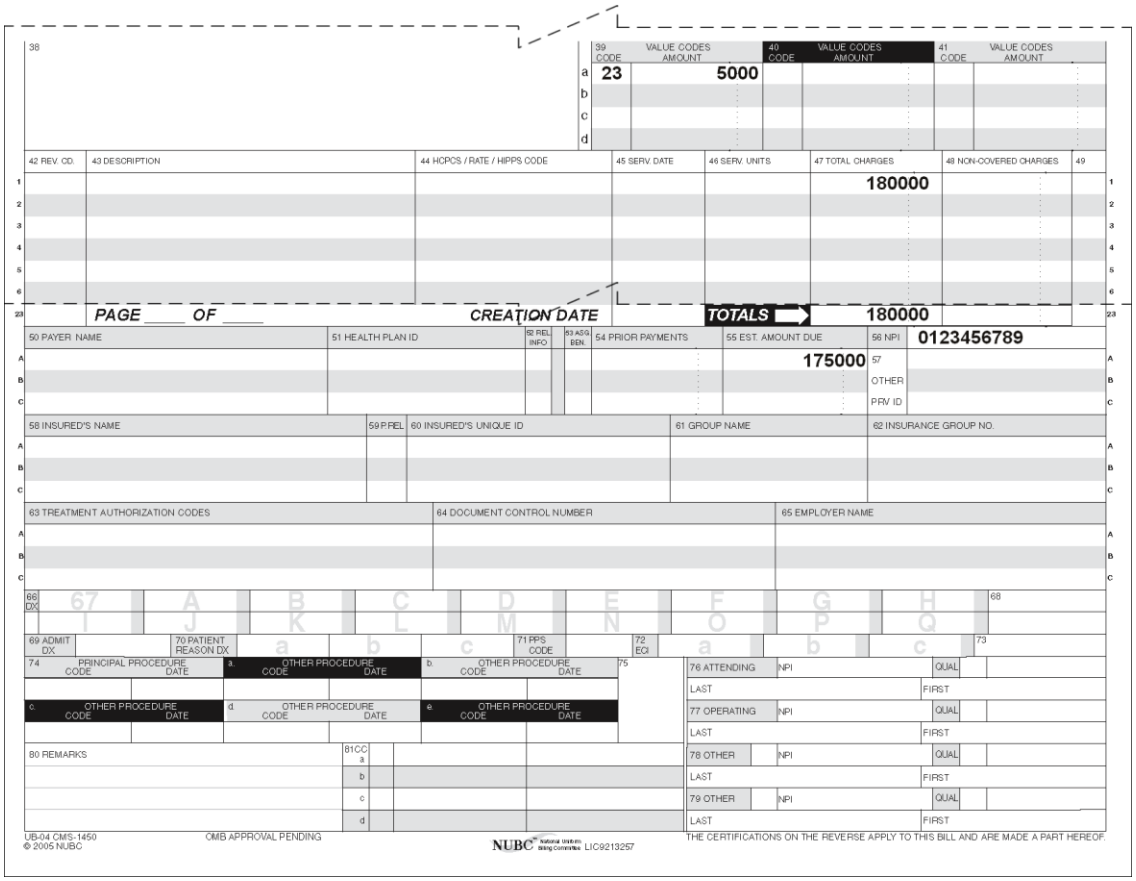
  Note: Value code “23” in the *Code* column field designates that the corresponding “amount” column contains the SOC.

Instructions

- Enter the full dollar and cents amounts, including zeros. Do not enter decimal points (.) or dollar signs ($).
- Use only one claim line for each service billed.

  Note: *Est. Amount Due* (Box 55) is the difference of *Total Charges* ($1800.00) less SOC ($50.00), which equals $1750.00.

Partial Example: the $50.00 SOC amount is entered as 5000.



Learning Activities

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.

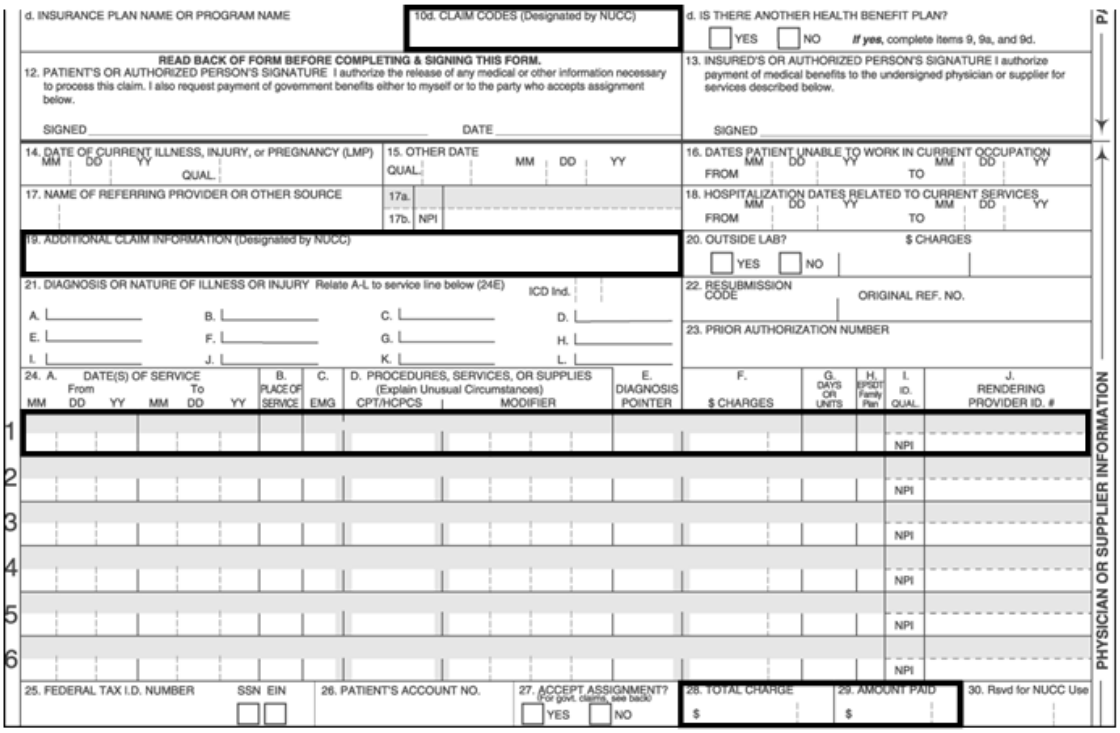
Dates	Service	Amount	SOC Cleared
06/01/18	Office Visit	$20.00	$20.00
06/14/18	Office Visit	$15.00	$15.00
06/15/18	Drainage	$20.00	$5.00
None	Total of Services	$55.00	$40.00

Knowledge Review 5

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

See the Appendix for the Answer Key.

Partial *CMS-1500* claim form



Activity 2: Multiple Services on Same Date

Case Scenario

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

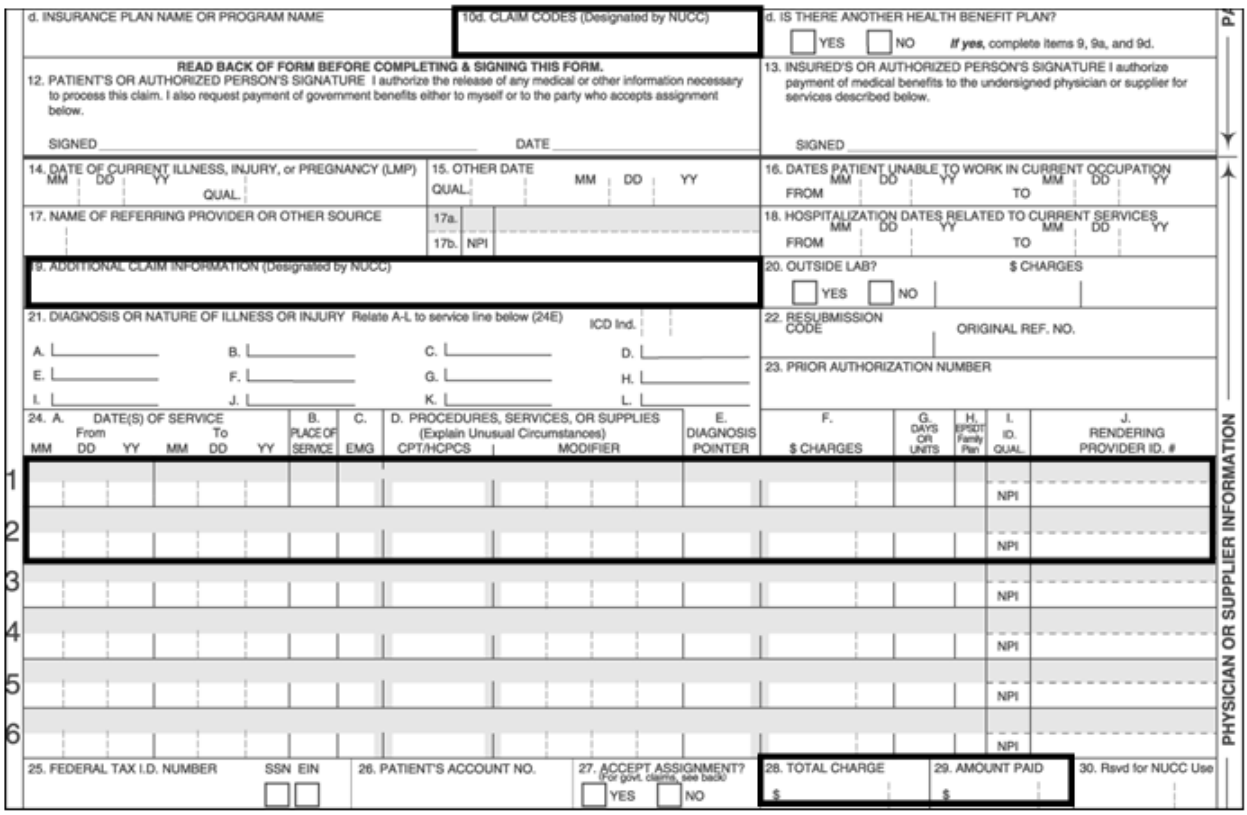
Dates	Service	Amount	SOC Cleared
06/02/18	Speech Evaluation (X4301)	$75.00	$75.00
06/02/18	Speech Therapy (X4303)	$50.00	$10.00
None	Total of Services	$125.00	$85.00

Knowledge Review 6

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

See the Appendix for the Answer Key.

Partial *CMS-1500* claim form



Activity 3: Inpatient Claim with SOC

Case Scenario

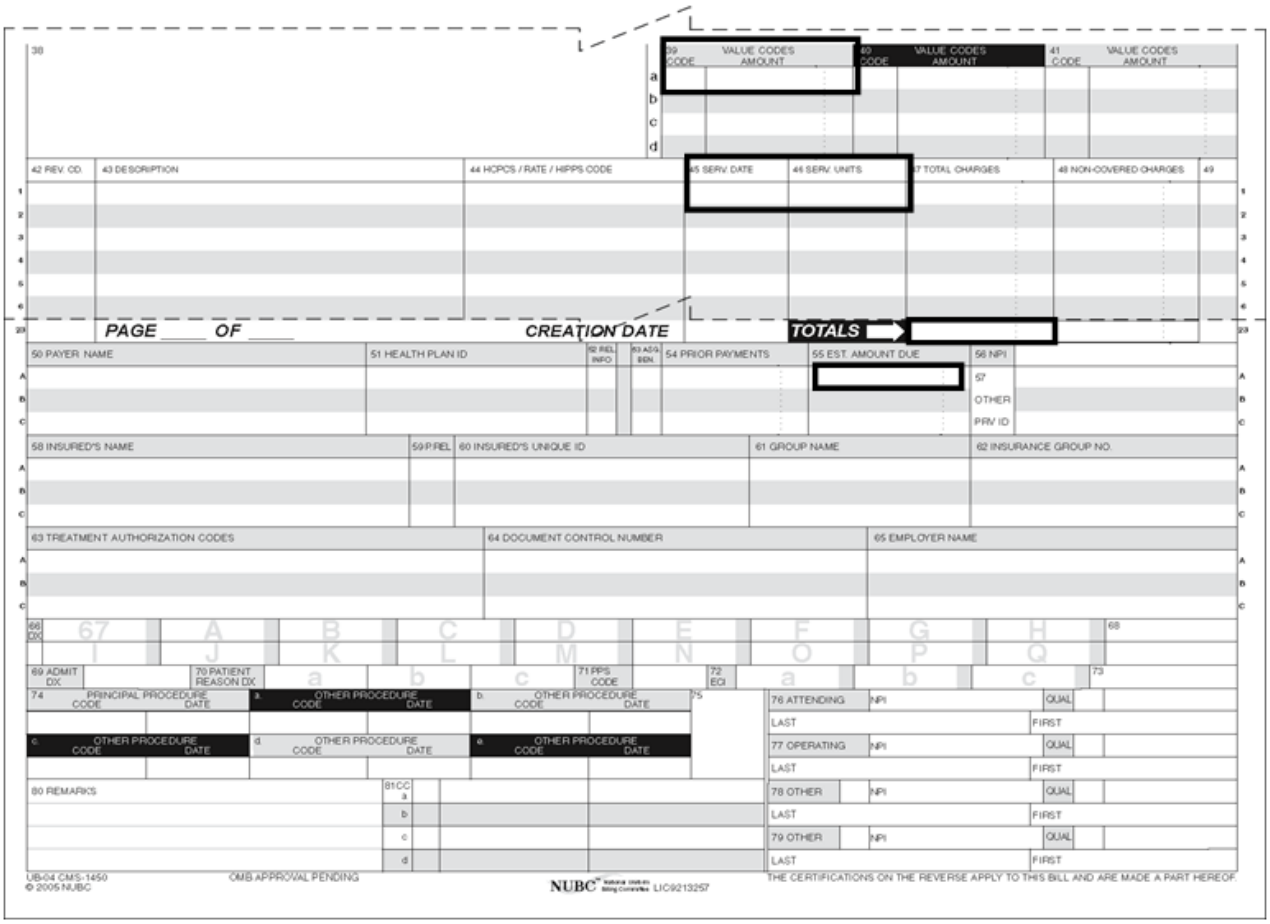
A recipient has a $100.00 SOC. She paid $50.00 to provider “A”, who performed a SOC spend down transaction for $50.00. The remaining $50.00 is paid or obligated to the hospital staff (provider “B”), which performs a second SOC clearance transaction. The recipient’s SOC is now fully certified. The total cost of services rendered for the inpatient claim is $3,430.50.

Knowledge Review 7

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

See the Appendix for the Answer Key.

Partial *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.

Activity 4: Multiple Services Rendered on Same Date of Service Outpatient Claim with SOC

Case Scenario

Two services are rendered to a recipient on the same date. In this case, the recipient visits the emergency room twice to see a doctor about recurring chest pains. The outpatient clinic bills for the room use, as well as the blood tests and handling. The recipient has a $60.00 SOC.

Dates	Service	Amount	SOC Cleared
06/18/18	E.R. room use (Z7502)	$50.00	$60.00
06/18/18	Panel Tests (80061)	$30.00	$0.00
06/18/18	Amino Acid Nitrogen (82127)	$15.00	$0.00
06/18/18	Collection and Handling (99000)	$5.00	$0.00
06/18/18	E.R. room use (Z7502)	$24.50	$0.00
None	Total of Services	$124.50	$60.00

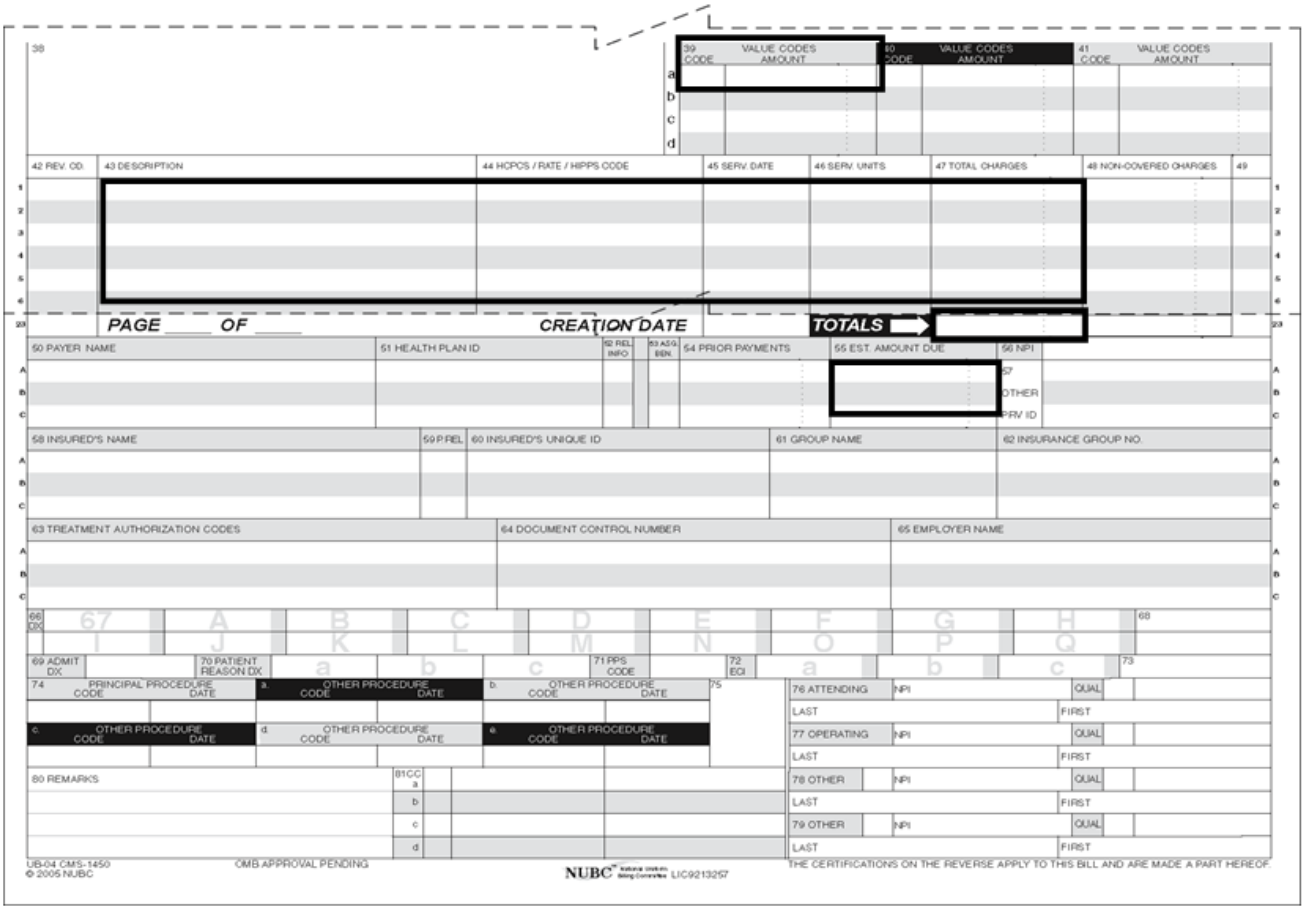
Notes:

Knowledge Review 8

What information will be submitted on this claim form based on the case scenario from the previous page? How will the collected SOC be entered on the claim form?

See the Appendix for the Answer Key.

Partial *UB-04* claim form



Resource Information

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)

Page updated: September 2020

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 and the Request for *Extension of Stay in Hospital* (18-1) form.

Module Objectives

- Explain TAR description and submissions
- Discuss medical justification and medical necessity documentation requirements
- Identify 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)

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete 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.

All paper TARs should be submitted to the TAR Processing Center. 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 one of the following addresses:

Attn: TAR Processing Center
California MMIS Fiscal Intermediary
820 Stillwater Road
West Sacramento, CA 95605-1630

Attn: TAR Processing Center
California MMIS Fiscal Intermediary
P.O. Box 13029
Sacramento, CA 95813-4029

Notes:

Documentation Requirements

Medical Justification

The provider is responsible for providing all necessary documentation and justification for TAR processing. Information regarding proper medical justification is found in the *TAR Overview* (tar) section in the Part 1 provider manual.

Medical Necessity

The Medi-Cal program defines medical necessity as the provision of health care services that are reasonable and necessary to protect life, prevent significant illness or significant disability or alleviate severe pain.

Authorization may be granted when the services requested are reasonably expected to:

- Restore lost functions
- Minimize deterioration of existing functions
- Provide necessary training in the use of orthotic or prosthetic devices
- Provide the capability for self-care, including feeding, toilet activities and ambulation

Authorization may be granted when failure to achieve the goals listed above would result in the loss of life or result in significant disability.

TAR 50-1 Form

Form Completion Process

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

Note: Refer to the *TAR Completion* (tar comp) section of the Part 2 provider manual for additional TAR completion instructions for Family PACT, BCCTP and HCPCS Code Conversion. The following pages include excerpts from the *TAR Completion* (tar comp) section.

If you are unsure if a procedure requires authorization, contact the California Medicaid Management Information System (California MMIS) Fiscal Intermediary Telephone Service Center (TSC) at 1-800-541-5555.

Treatment Authorization Request (50-1) Form

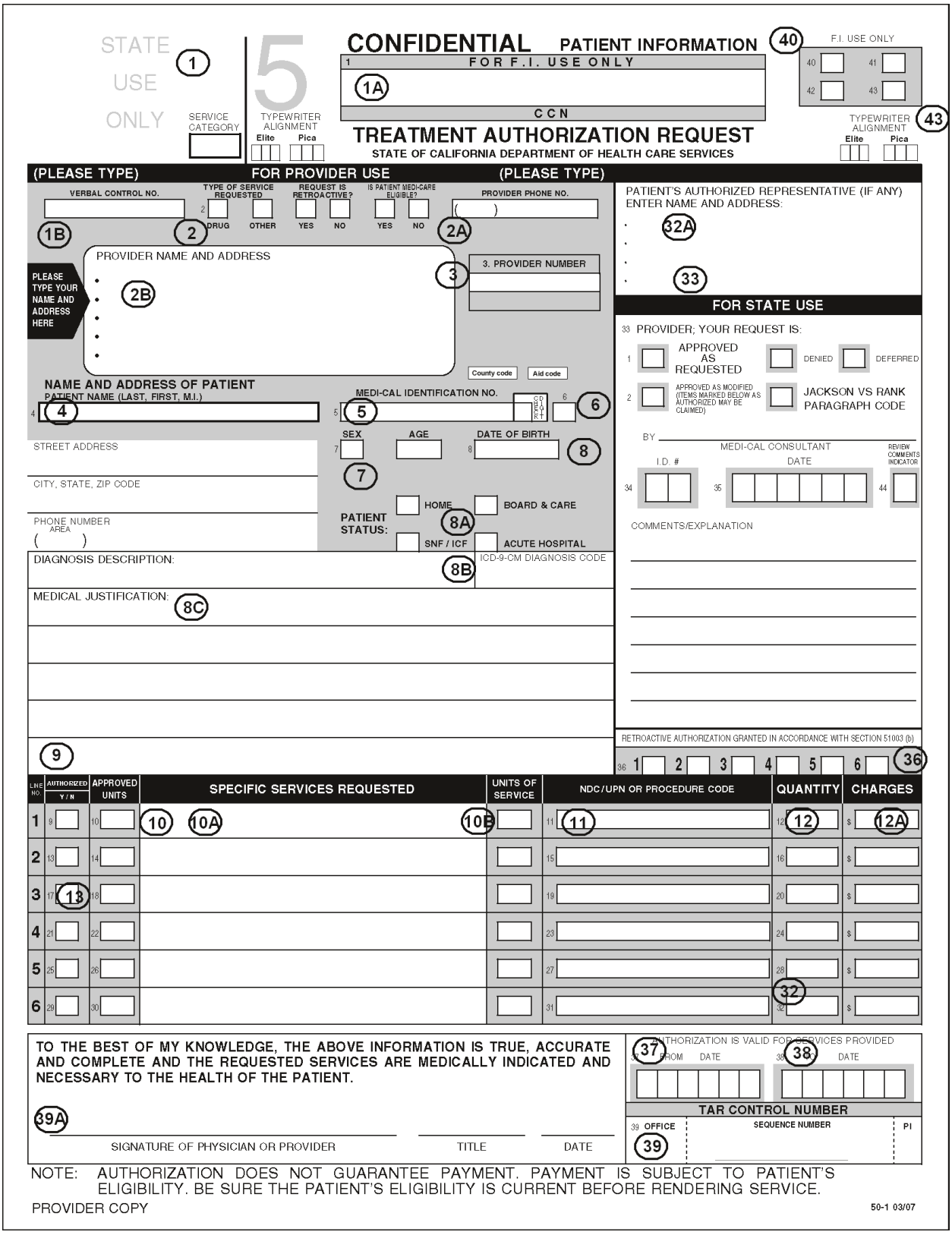


Table of TAR 50-1 Form Fields and Instructions

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. All other providers will not receive an AR by fax and should leave this field blank.
2	Type of Service Requested/ Retroactive Request/Medicare Eligibility Status	Enter an "X" in the appropriate boxes to show Drug or Other, Retroactive request and Medicare eligibility status
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 *Medical Justification* 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. Do not enter any characters (dashes, hyphens, special characters) in the remaining blank positions of the *Medi-Cal ID* field or in the *Check Digit* box. The county code and aid code must be entered just above the recipient Medi-Cal Identification Number field.
6	Pending	Leave blank.

Table of TAR 50-1 Form Fields and Instructions, Continued

Locator #	Form Field	Instructions
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 *Medical Justification* field.

Notes:

Table of TAR 50-1 Form Fields and Instructions, Continued

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 *Medical Justification* field. Family PACT: 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 *Family PACT Referral* form from the enrolled Family PACT provider. **Note:** For BCCTP requests: providers requesting services of an urgent nature in relation to breast and cervical cancer treatment for a recipient with a BCCTP aid code should enter the words "URGENT/BCCTP" in bold, black letters in this field. TARs for HCPCS Code Conversions: providers should write "Code Conversion TAR" and the previously approved TAR number in this area. For more information about code conversion TARs, see "Local-to-HCPCS Code Conversion Guidelines" in this section.
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."

Table of TAR 50-1 Form Fields and Instructions, Continued

Locator #	Form Field	Instructions
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 *Taxable* and *Non-Taxable Items* (tax) section in the appropriate Part 2 provider manual.
13 thru 32	Additional Lines 2 thru 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.
33 thru 36	For State Use	Leave blank. Consultant's determination and comments will be returned on the AR. **Note:** Only submit the claim if the AR decision is Approved as Requested or Approved as Modified. Denied and deferred decisions indicate that the provider's request has not been approved.
37 thru 38	Authorization is Valid for Services Provided From Date/To Date	Leave blank. The AR will indicate valid dates of authorization for the TAR.

Table of TAR 50-1 Form Fields and Instructions, Continued

Locator #	Form Field	Instructions
39	TAR Control Number	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. Do not attach a copy of the AR to the claim form. The TAR Control Number on a TAR 50-1 may serve as the initial admit TAR # on an elective admission for the hospital.
39A	Signature of Physician or Provider	Form must be signed by the physician, pharmacist or authorized representative.
40 thru 43	F.I. Use Only	Leave blank.

Knowledge Review 1

List two requirements for a retroactive TAR.

1.) _____

2.) _____

See the Appendix for the Answer Key.

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

Form Completion Process

Information regarding *Request for Extension of Stay in Hospital* (18-1) form is located in the *TAR Request for Extension of Stay in Hospital (Form 18-1)* (tar req ext) section and the *Diagnosis-Related Groups (DRG): Inpatient Services* (diagnosis ip) section in the Part 2 *Inpatient Services* provider manual. The following pages include excerpts from the TAR 18-1 form section.

Emergency Admissions (18-1 TAR)

Authorization for hospital emergency admissions is always requested by the hospital on a *Request for Extension of Stay in Hospital* (18-1). All non-emergency, non-obstetrical admissions require authorization on a 50-1 TAR.

If the emergency admission does not meet the definition of emergency services as set forth in *California Code of Regulations* (CCR), Title 22 Section 51056(a), the Medi-Cal consultant will deny the day of admission. (See CCR, Title 22, Section 51056[b]). The denial of the day of admission will apply to all types of admissions (medical, surgical, psychiatric, etc.).

Diagnosis-Related Groups (DRG)

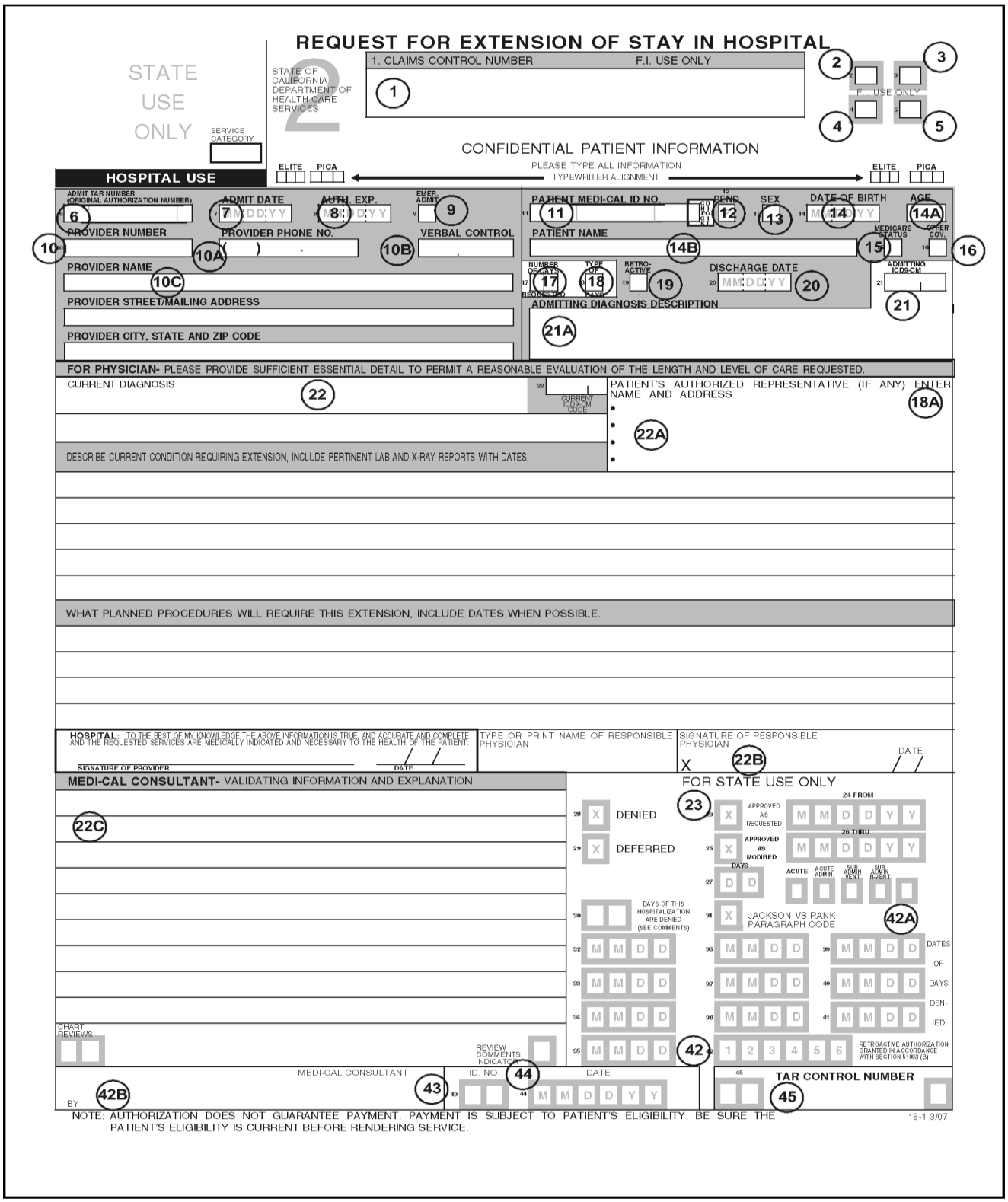
To be reimbursed, most inpatient services require authorization. Claims submitted for services rendered without an approved TAR may be denied.

Note: Obstetric admissions associated with a delivery do not require either an admit or daily TAR in cases where both the mom and newborn remain healthy. If the newborn becomes sick, an admit TAR must be submitted for the entire hospital stay, starting the day of admission. Refer to “Admit TAR and Daily TAR” information in this section for more information.

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).

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



REQUEST FOR EXTENSION OF STAY IN HOSPITAL

STATE USE ONLY

SERVICE CATEGORY

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

1. CLAIMS CONTROL NUMBER F.I. USE ONLY

F.I. USE ONLY

CONFIDENTIAL PATIENT INFORMATION

PLEASE TYPE ALL INFORMATION
TYPEWRITER ALIGNMENT

ELITE PICA

HOSPITAL USE

ADMIT TAR NUMBER (ORIGINAL AUTHORIZATION NUMBER) 6

ADMIT DATE 7 MM DD YY

AUTH. EXP. 8 MM DD YY

EMER. ADMIT 9

PATIENT MEDI-CAL ID NO. 11

CD PI EG CT 12

PEND 12

SEX 13

DATE OF BIRTH 14 MM DD YY

AGE 14A

PROVIDER NUMBER 10

PROVIDER PHONE NO. ( ) 10A

VERBAL CONTROL 10B

PATIENT NAME 14B

MEDICARE STATUS 15

OTHER COV. 16

PROVIDER NAME 10C

NUMBER OF DAYS REQUESTED 17

TYPE OF DAYS 18

RETRO-ACTIVE 19

DISCHARGE DATE MM DD YY 20

ADMITTING ICD9-CM 21

PROVIDER STREET/MAILING ADDRESS

ADMITTING DIAGNOSIS DESCRIPTION 21A

PROVIDER CITY, STATE AND ZIP CODE

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

CURRENT DIAGNOSIS 22

CURRENT ICD9-CM CODE 22

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS 18A

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.

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

SIGNATURE OF PROVIDER DATE

TYPE OR PRINT NAME OF RESPONSIBLE PHYSICIAN

SIGNATURE OF RESPONSIBLE PHYSICIAN X 22B DATE

MEDI-CAL CONSULTANT- VALIDATING INFORMATION AND EXPLANATION

22C

FOR STATE USE ONLY

23

DENIED

DEFERRED

APPROVED AS REQUESTED

APPROVED AS MODIFIED

24 FROM

26 THRU

DAYS

ACUTE ACUTE ADMIN SUB ADMIN VENT SUB ADMIN P/VENT

DAYS OF THIS HOSPITALIZATION ARE DENIED (SEE COMMENTS)

JACKSON VS RANK PARAGRAPH CODE 42A

DATES OF DAYS DEN-IED

CHART REVIEWS

REVIEW COMMENTS INDICATOR

42

1 2 3 4 5 6 RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (B)

MEDI-CAL CONSULTANT 43

ID. NO. 44

DATE 44 MM DD YY

TAR CONTROL NUMBER 45

BY 42B

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

Table of TAR 18-1 Form Fields and Instructions

Locator #	Form Field	Instructions
1	Claims Control Number	Leave blank. For FI use only.
2 thru 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. The *Emergency Admit* field (Box 9) must be left blank when the *Admit TAR Number* field is completed. For emergency admits, refer to Item 9.
7	Admit Date	Enter the date of admission using the six-digit format (MMDDYY).
8	Authorization Expires	Enter the date the current TAR expires.

Table of TAR 18-1 Form Fields and Instructions, Continued

Locator #	Form Field	Instructions
9	Emergency Admit	Enter an "X" if the patient was admitted to the hospital on an emergency basis and this is the initial authorization. Leave blank on subsequent extension TARs for the recipient. Refer to a previous page for detailed information about emergency admissions. Providers requesting an approval of emergency admission, transfer or extension of hospital stay on the 18-1 form must complete the following fields accurately: • The *Patient Medi-Cal ID No.* (Box 11) should be copied from the patient's current BIC and must match the ID number on the claim form. This recipient identifier is either the 14-digit recipient ID, the nine-digit CIN from the BIC or the nine-digit SSN. When using the SSN, enter the county code and aid code below Box 11. • The *Provider Number* (Box 10) should be complete and correct provider number of the hospital (nine digits). • The *Number of Days Requested* (box 17) is the total number of days requested on this extension. • The *Admitting ICD-9-CM* (Box 21) and *Current ICD-9-CM* (Box 22) should be completed using the *International Classification of Diseases, 10th Revision, Clinical Modification*. **Note:** This form has not been updated to reflect an ICD-10-CM field label name. The *Admit TAR Number (Original Authorization Number)* (Box 6) should contain the TAR Control Number (TCN) from the TAR (50-1) for elective and urgent admissions. On emergency admissions, the TCN from the original or first 18-1 is placed in the *Admit TAR Number* box. The Admit TAR Number is used to link subsequent extensions to the original admitting TAR for the purpose of claims submittal.
10	Provider Number	Enter the Provider Number/NPI
10A	Provider Phone Number	Enter the provider's telephone number including area code.

Table of TAR 18-1 Form Fields and Instructions, Continued

Locator #	Form Field	Instructions
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, the nine-digit CIN from the BIC or the nine-digit SSN (without the check digit placed in this *Patient Medi-Cal ID No.* field). Enter the county code and aid code below Box 11.
12	Pend	Leave blank.
13	Sex	Enter the patient's gender. • "F" for female • "M" for male
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.

Notes:

Table of TAR 18-1 Form Fields and Instructions, Continued

Locator #	Form Field	Instructions
15	Medicare Status	If Medicare is not billed, enter the appropriate Medicare status code number. Refer to *the UB-04 Completion: Inpatient Services* section in the manual for a listing of Medicare status codes. **Note:** 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.
16	Other Coverage	Enter an "X" if the recipient has other insurance or Other Health Coverage (OHC). **Note:** Eligibility under Medicare is not considered other coverage. Refer to the Other Health Coverage (OHC) Guidelines for Billing section in the Part 1 manual for information on OHC and the coding system used in connection with billing OHC carriers and/or Medi-Cal.
17	Number of Days	Enter the number of days requested on the TAR. This requirement applies to hospitals, regardless of diagnosis-related groups' (DRG) reimbursement, billing for restricted aid codes as well as administrative and rehabilitation services. DRG Admit TAR: Enter "1". Daily TAR: Enter the number of days requested. An admit TAR is a TAR that is submitted to request authorization for the entire hospital stay. It differs from a daily TAR that identifies the specific number of hospital days for which authorization is requested.
18	Type of Days	Enter the code indicating type of days requested. 0: Acute 2: Administrative 3: Subacute administrative ventilator dependent 4: Subacute administrative non-ventilator dependent
19	Retroactive	Enter a capital "X" if this request is retroactive.
20	Discharge Date	Enter the date the patient was discharged from the facility. DRG: Enter the date following the date of admission.
21	Admitting ICD-9-CM	Enter the numeric code for the admitting diagnosis from the ICD-10-CM codebook.

Table of TAR 18-1 Form Fields and Instructions, Continued

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. If the patient is admitted from a Nursing Facility Level A (NF-A) or Nursing Facility Level B (NF-B), enter the name of the facility in the description of condition block. On requests submitted by a non-medical provider, the full name of the prescriber and office telephone number must appear in the lower left-hand corner of this section, for example, John J. Smith, M.D., (916) 100-0000.
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.
22C	Medi-Cal Consultant – Validating Information and Explanation.	Leave blank; for Medi-Cal consultant use only.
23 thru 42	For State Use Only	Leave blank.
42A	Sub. Admin. Vent/Sub Admin N-Vent	Leave blank. 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.

Table of TAR 18-1 Form Fields and Instructions, Continued

Locator #	Form Field	Instructions
42B	Medi-Cal Consultant	Leave blank.
43 thru44	ID. No./Date	Leave blank, for Medi-Cal consultant use only.
45	TAR Page updated: September 2020	This number is imprinted on the form and will have a prefix and suffix added to it by the Medi-Cal consultant. Leave blank.

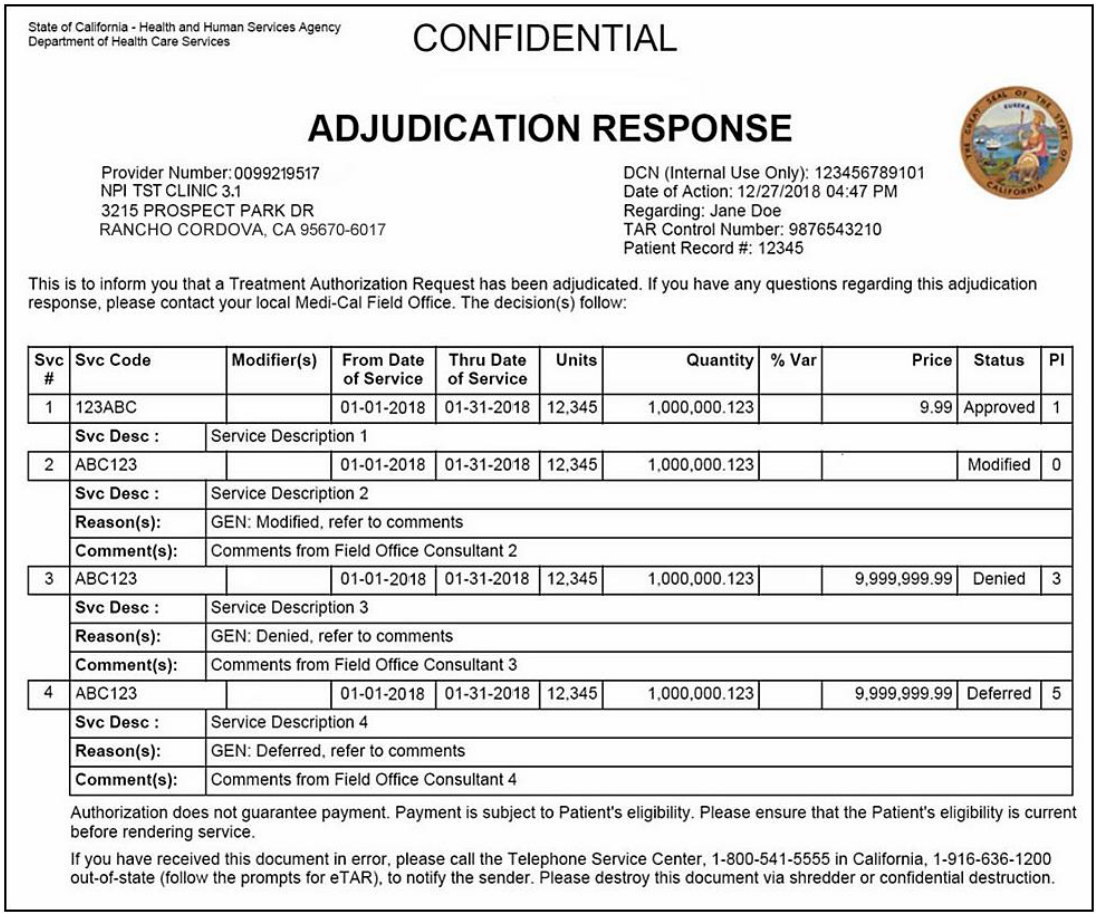
Authorization Findings

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

CONFIDENTIAL

ADJUDICATION RESPONSE

Provider Number: 0099219517
NPI TST CLINIC 3.1
3215 PROSPECT PARK DR
RANCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101
Date of Action: 12/27/2018 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		01-01-2018	01-31-2018	12,345	1,000,000.123		9.99	Approved	1
	Svc Desc :	Service Description 1								
2	ABC123		01-01-2018	01-31-2018	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		01-01-2018	01-31-2018	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		01-01-2018	01-31-2018	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								

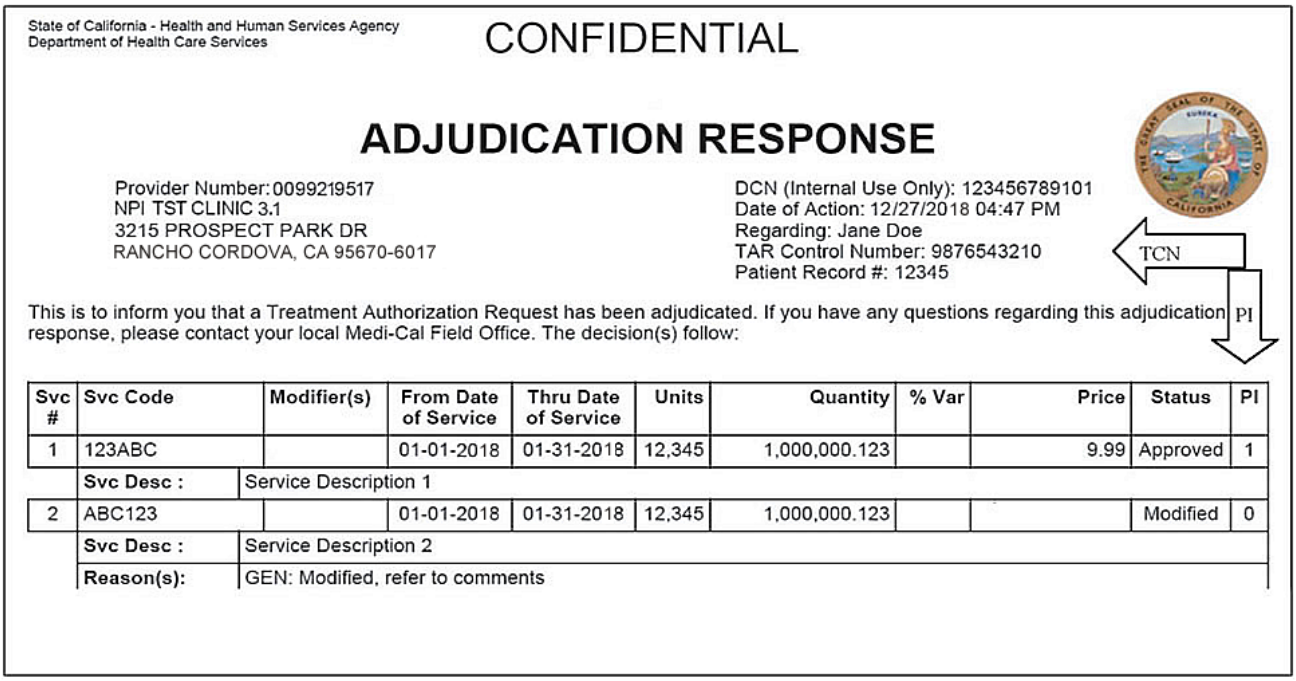
Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service.

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 Control Number and Pricing Indicator

The last column on the AR will contain the Pricing Indicator (PI) number.

When submitting claims, the PI number should be included as the last digit (11th) of the TAR Control Number (TCN). Failure to use the PI when billing will cause the claim to be denied.



State of California - Health and Human Services Agency
Department of Health Care Services

CONFIDENTIAL

ADJUDICATION RESPONSE

Provider Number: 0099219517
NPI TST CLINIC 3.1
3215 PROSPECT PARK DR
RANCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101
Date of Action: 12/27/2018 04:47 PM
Regarding: Jane Doe
TAR Control Number: 9876543210
Patient Record #: 12345

TCN

PI

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		01-01-2018	01-31-2018	12,345	1,000,000.123		9.99	Approved	1
	Svc Desc :	Service Description 1								
2	ABC123		01-01-2018	01-31-2018	12,345	1,000,000.123			Modified	0
	Svc Desc :	Service Description 2								
	Reason(s):	GEN: Modified, refer to comments								

Knowledge Review 2

What is the 11-digit TCN that will be used when submitting a claim for service #1?

__ __ __ __ __ __ __ __ __ __ __

See Appendix for the Answer Key.

Notes:

TAR Form Submission

Submission Method

Providers are encouraged to use electronic TAR (eTAR) submission, which offers faster and more efficient document turnaround and payments. Providers may also submit TARs by mail. All paper TARs must be submitted to the TAR Processing Center. Refer to the “TAR Description” section of this module for more information.

Where to Submit TARS

All paper TARs should be submitted to the TAR Processing Center. Adjudication assignments remain as listed for core and regionalized services. Providers should not submit paper TARs to Medi-Cal field offices. To submit paper TARs, mail the TAR 50-1 form or the TAR 18-1 form to one of the following addresses:

Attn: TAR Processing Center
California MMIS Fiscal Intermediary
820 Stillwater Road
West Sacramento, CA 95605-1630

Attn: TAR Processing Center
California MMIS Fiscal Intermediary
P.O. Box 13029
Sacramento, CA 95813-4029

Resource Information

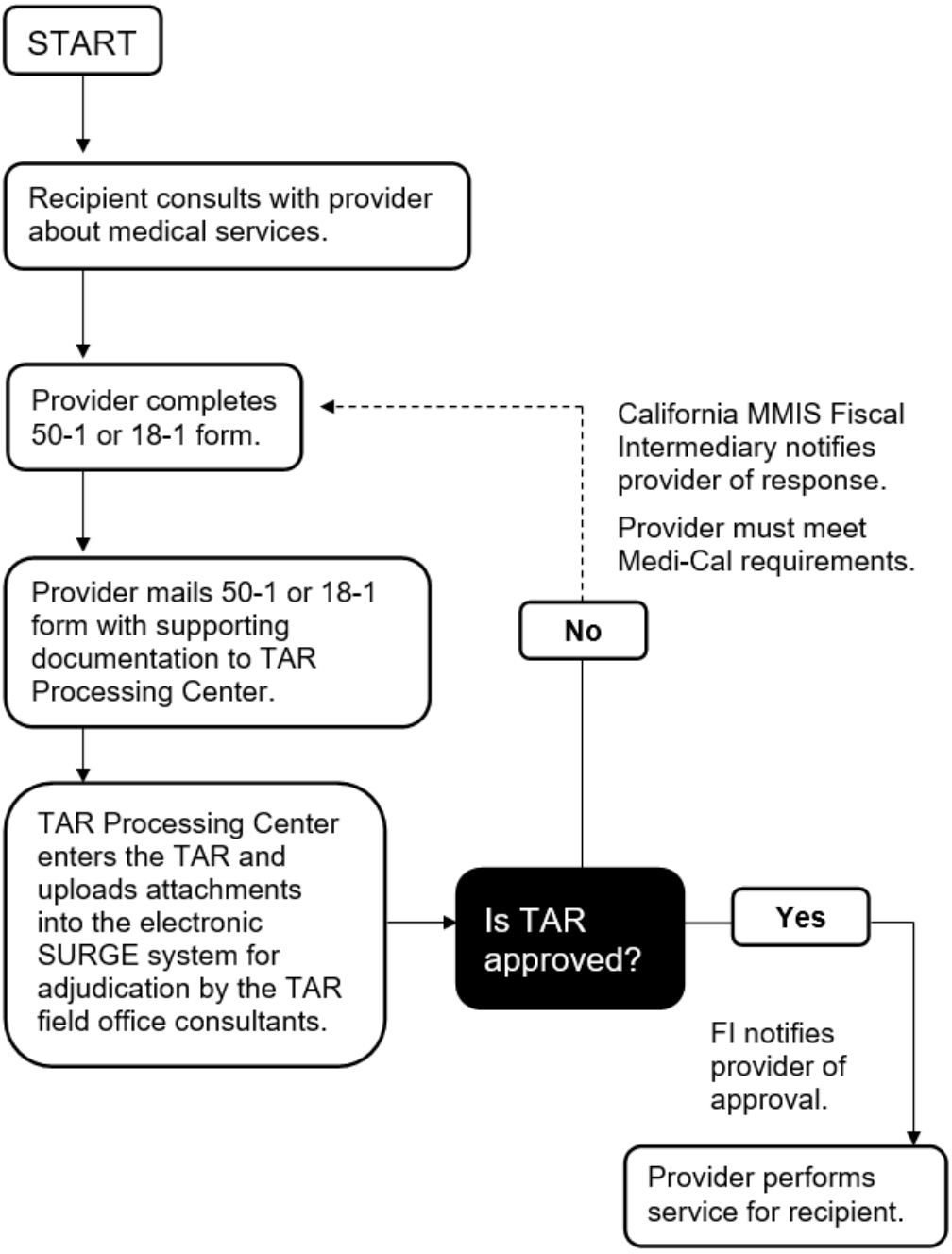
Additional information can be found in the provider manual.

- The *TAR Field Office Addresses* (tar field) section 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* (tar sub drug) section 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 a provider uses when requesting Medi-Cal authorization to perform medical services with a 50-1 or 18-1 TAR form.



Resource Information

References

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

Provider Manual References

Part 1

TAR Overview (tar)

Part 2

Diagnosis-Related Groups (DRG): Inpatient Services (diagnosis ip)
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 (CCR),* Title 22

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 required by the Medi-Cal program.

Module Objectives

Introduce general *CMS-1500* claim form billing guidelines

Identify field-by-field instructions for the completion and submission of the *CMS-1500* claim form

Discuss common claim form completion errors

Participate in an interactive claim completion learning activity

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete 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 California Medicaid Management Information System (CA-MMIS) 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 Completion 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 not acceptable.
- 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.
- All dates are entered without slashes. Do not use punctuation, such as decimal point (.) dollar sign ($), positive (+) or negative (-) symbol when entering amounts.

Claim Reimbursement Guidelines

Claim Submission Timeliness Requirements

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

Full Reimbursement Policy

Table of Reimbursement Deadlines

If the Date of Service (DOS) falls within this month:	Then claims must be received by 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 California MMIS Fiscal Intermediary without a valid delay reason will be reimbursed at a reduced rate according to the date in which the claim was received.

Partial reimbursement rates are paid as follows:

- 100% Reimbursement from 0 to the end of 6 months.
- 75% Reimbursement from 7 months to the end of 9 months.
- 50% Reimbursement from 10 months to the end of a year.

Delay Reason Codes

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 reason for late claim submission, these exceptions also have time limits. For a complete description of the Delay Reason Codes refer to the *CMS-1500 Submission and Timeliness Instructions* section (cms sub) of the Part 2 provider manual.

Table of Delay Reason Codes

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 (eg. theft); attach documentation justifying delay reason
15	Natural disaster

Note: To receive full payment, providers must attach documentation justifying the delay reason. Providers billing with a delay reason code without the required attachments will be denied or reimbursed at a reduced rate.

Billing Notice: Most providers may no longer bill Medi-Cal or CCS using a recipient's Social Security Number (SSN). Claims submitted with a recipient's SSN will be denied.

CMS-1500 Delay Reason Code Claim Example

For the *CMS-1500* form, enter a delay reason code in the unshaded area of the *EMG* field (Box 24C) when the claim is beyond the six-month billing limit. If an emergency code is listed in the unshaded area, place the delay reason code in the shaded area.

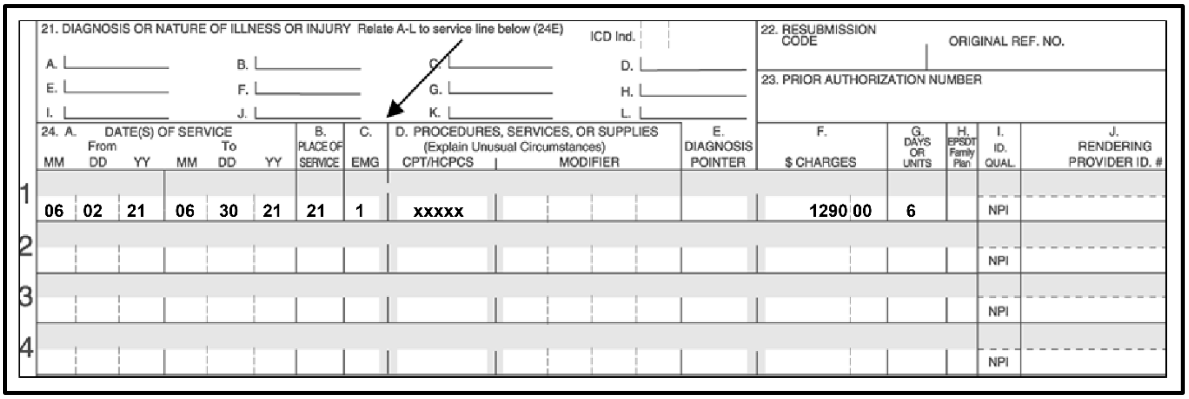


Figure 1: EMG Field on the *CMS-1500* Form

Claims Beyond 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 California MMIS Fiscal Intermediary at the following address:

Attn: Over One Year Claims Unit
California MMIS Fiscal Intermediary
P.O. Box 13029
Sacramento, CA 95813-4029

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.

Refer to the appropriate Part 2 provider manual section: *CMS-1500: Submission and Timeliness Instructions* (cms sub).

Form Completion Instructions

- Handwritten claims should be printed neatly using black ballpoint pen ONLY. Do not use red pencils or red ink ballpoint pens.
- 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 envelops 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 “ABK” 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, 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:

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 transactions.

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

California MMIS Fiscal Intermediary
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.

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 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.

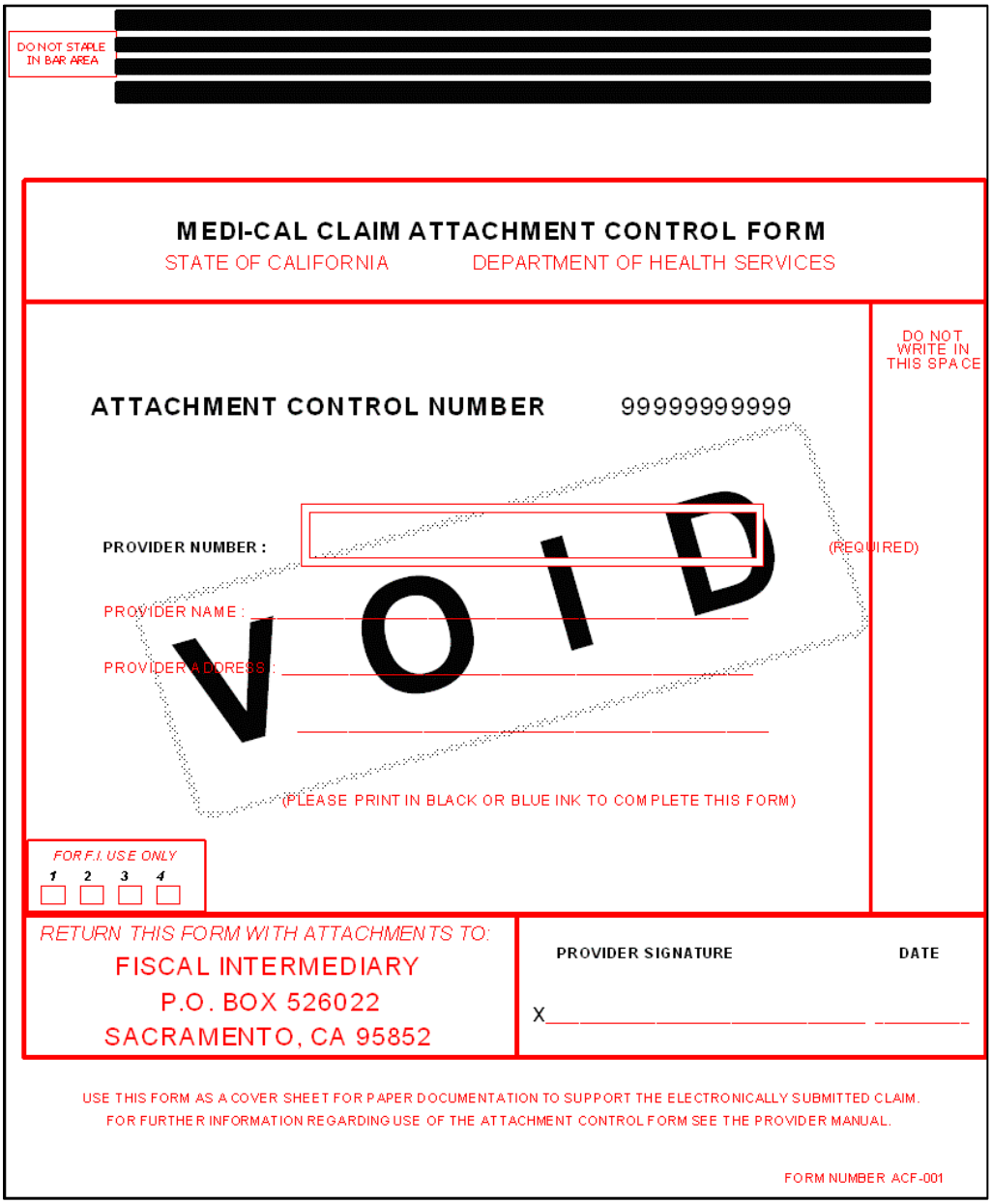
ACF Order/Reorder Instructions

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) of the Part 2 provider manual or visit the Medi-Cal website (*www.medi-cal.ca.gov*).

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



Sample ACF

California MMIS
Fiscal Intermediary

P.O. Box 13029
Sacramento, CA 95813-4029

1.800.541.5555

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 Care Services (DHCS) 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: California MMIS 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 (TSC) at 1-800-541-5555.

Sincerely,

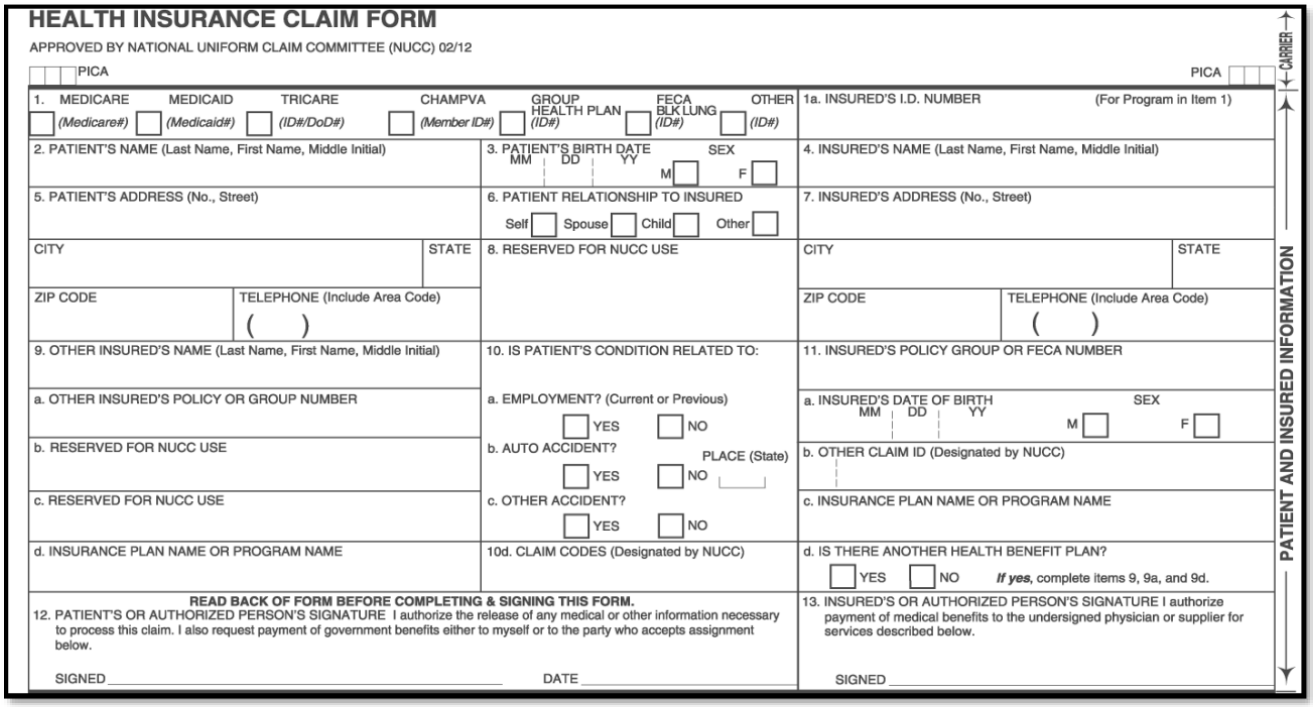
California Medicaid Management Information System Fiscal Intermediary

Sample: ACF Rejection Letter

CMS-1500 Claim Form Completion

CMS-1500 Claim Form **(Fields 1 thru 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

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area 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) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES 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? YES NO *If yes,* complete items 9, 9a, and 9d.

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 _____

CARRIER

PATIENT AND INSURED INFORMATION

Sample: Partial *CMS-1500* Claim Form

Notes:

_____

_____

_____

_____

_____

_____

_____

Table of Field Descriptions for the CMS-1500 Claim Form

Box #	Field Name	Instructions	Billing Tip
1	Medicaid/ Medicare/ Other Id	For Medi-Cal, enter an "X" in the *Medicaid* box.	When billing Medicare crossover claims, check both the Medicaid and Medicare 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 infant for the month of birth or the following month, enter the mother's ID number in this field.	Use the POS Network 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. *A comma is required between recipient's last name, first name and middle initial (if known).*	**Newborn Infant:** 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 BABY BOY or BABY GIRL.
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.	**Newborn Infant:** Enter the infant's sex and date of birth in Box 3.
4	Insured's Name	*Not required by Medi-Cal,* except when billing for a newborn using the mother's ID. Enter the mother's name in this field when billing for the newborn.	**Newborn Infant:** Enter the mother's name in the Insured's Name field (Box 4).
5	Patient's Address and Telephone	Enter the recipient's complete address and telephone number.	None.

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

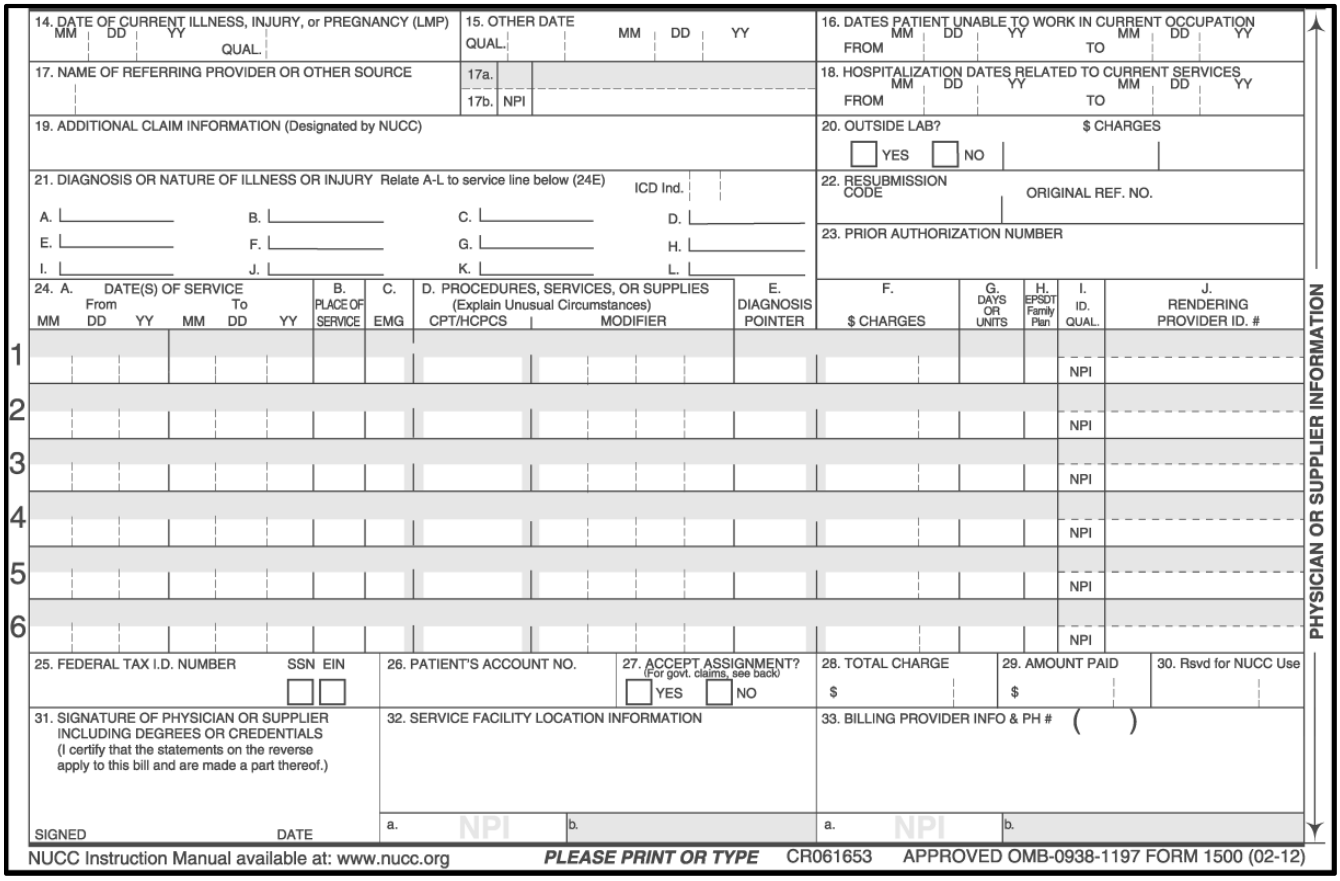
Box #	Field Name	Instructions	Billing Tip
6	Patient's Relationship to Insured	*Not required by Medi-Cal.* This field should be used when billing for an infant using the mother's ID by checking the *Child* box.	None
10A	Employment	Complete this field if services were related to an accident or injury. • Enter an "X" in the Yes box if accident/injury is employment related. • Enter an "X" in the No box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in the *Date of Current Illness, Injury or Pregnancy* field (Box 14).	None
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).	None

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
11D	Another Health Benefit Plan	Enter an "X" in the Yes 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.	Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient's other health coverage prior to billing Medi-Cal. Eligibility under Medicare or Medi-Cal Managed Care Plan (MCP) is not considered OHC.

Notes:

CMS-1500 Claim Form **(Fields 14 thru 33)**



Sample: Partial *CMS-1500* Claim Form

Notes:

_____

_____

_____

_____

_____

_____

_____

Table of Field Descriptions for the CMS-1500 Claim Form

Box #	Field Name	Instructions	Billing Tip
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). Medi-Cal does not require a qualifier (QUAL) in this field.	None.
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. The NPI of the supervising physician needs to be entered in box 17B, below. **Note:** Provider's billing lab services for residents in a Skilled Nursing Facility (NF) Level A or B are required to enter the NF-A as the referring provider.	None

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
17B	NPI (Of Referring Physician)	Enter the 10-digit NPI. The following providers must complete Box 17 and Box 17B: • Audiologist • Clinical laboratory (services billed by laboratory) • Durable Medical Equipment (DME) and medical supply • Hearing aid dispenser • Nurse anesthetist • Occupational therapist • Orthotist • Pharmacist • Physical therapist • Podiatrist (services are rendered in a Skilled Nursing Facility [NF] Level A or B) • Portable imaging services • Prosthetist • Radiologist • Speech pathologist	None
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.	None

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
19	Additional Claim Information (Designated by NUCC)	Use this area for procedures that require additional information, justification or an *Emergency Certification Statement.*	"By Report" codes, complicated procedures, unlisted services and anesthesia time require attachments. 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.	None
21	Diagnosis or Nature of Illness or Injury Relate A thru L to service line below (24E)	Claims with a diagnosis code must include the ICD indicator "0". Medi-Cal requires providers to enter the ICD indicator "0". **Note:** Claims submitted without a diagnosis code do not require an ICD indicator.	None
21A	Diagnosis or Nature of Illness or Injury	Enter all letters and/or numbers of the ICD-10-CM diagnosis code for the primary diagnosis, including fourth through seventh characters, if present. (Do not enter decimal point). The following services are exempt from diagnosis descriptions and codes when they are the only services billed on the claim: 1. Anesthesia services 2. Assistant surgeon services 3. Medical supplies 4. Medical transportation 5. Pathology services 6. Radiology services (exceptions: CAT scan, nuclear medicine, ultrasound, radiation therapy and portable imaging services).	None

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
21B	Diagnosis or Nature of Illness or Injury	If applicable, enter all letters and/or numbers of the secondary ICD-10-CM diagnosis code, including fourth through seventh characters, if present. (Do not enter decimal point.)	None
21C thru L	Diagnosis or Nature of Illness or Injury	Not required by Medi-Cal. Medi-Cal only accepts two diagnosis codes. Codes entered in Boxes 21.C thru L will not be used for claims processing.	None
22	Resubmission Code	Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional.	None
23	Prior Authorization Number	Physician and podiatry services requiring a *Treatment Authorization Request* (TAR) must enter the 11-digit TAR Control Number (TCN). For California Children's Services (CCS) claims, enter the 11-digit Service Authorization Request (SAR) number. It is not necessary to attach a copy of the TAR to the claim. **Note:** TAR and non-TAR procedures should not be combined on the same claim.	Recipient information on the claim must match the TAR/SAR. Only one TCN can cover the services billed on any one claim.

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
24A	Date(s) of Service	Enter the date the service was rendered in the From and To 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 *From* box in Field 24A. **National Drug Code (NDC) for Physician Administered Drugs:** In the shaded area, enter the product ID qualifier N4 followed by the 11-digit NDC (no spaces or hyphens). **Universal Product Number (UPN) for contracted disposable incontinence and medical supplies:** In the shaded area, enter the appropriate UPN qualifier followed by the UPN. Refer to the *Physician-Administered Drugs – NDC: CMC-1500 Billing Instructions* section (physician ndc cms) in the Part 2 provider manual.	None
24B	Place of Service	Enter the two-digit national Place of Service code in the unshaded area, indicating where the service was rendered.	The national Place of Service codes are listed in the *CMS-1500 Completion* section (cms comp) in the Part 2 provider manual.

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
24C	EMG	Emergency or Delay Reason Codes. **Delay Reason Code**: 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. **Emergency Code:** Enter an "X" when billing for emergency services, or the claim may be reduced or denied. Only one emergency indicator is allowed per claim, and must be placed in the unshaded, bottom portion of Box 24C. An Emergency Certification Statement is required for all services rendered under emergency conditions. The statements must be signed and dated by the provider and must describe the nature of the emergency including clinical information about the patient's condition. A mere statement that an emergency occurred is not sufficient. The Emergency Certification Statement may be attached to the claim or entered in Box 19 "Additional Claim Information" field.	None

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
24D	Procedures, Services or Supplies/ Modifier	Enter the appropriate procedure code (CPT or HCPCS) and modifier(s).	The descriptor for the procedure code must match the procedure performed, and the modifier(s) must be billed appropriately. Do not submit multiple National Correct Coding Initiative (NCCI)-associated modifiers on the same claim line. If necessary, the procedure description can be entered in the *Additional Claim Information* field (Box 19). 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.
24E	Diagnosis Pointer	As required by Medi-Cal.	

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
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.” If an item is a taxable medical supply, include the applicable state and county sales tax.	None
24G	Days or Units	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. For entries greater than 999, carry the remaining value to the next claim line.	Providers billing for units of time should enter the time in 15-min increments. For example, one hour should be entered as “4.”
24H	EPSDT Family Plan	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.	Refer to the *Family Planning* section (fam planning) of the appropriate Part 2 provider manual for additional details.
24J	Rendering Provider ID #	Enter the NPI for a rendering provider (unshaded area) if the provider is billing under a group NPI. If the provider is not billing under a group NPI, leave this field blank in order for claims to be reimbursed correctly. This applies to all services.	If an error has been made to specific billing information entered on items 24A thru 24J, draw a line through the entire detail using a black ballpoint pen. Enter the <u>correct</u> billing information on another line. Do not black out the entire claim line. Deleted information may be used to determine previous payment

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

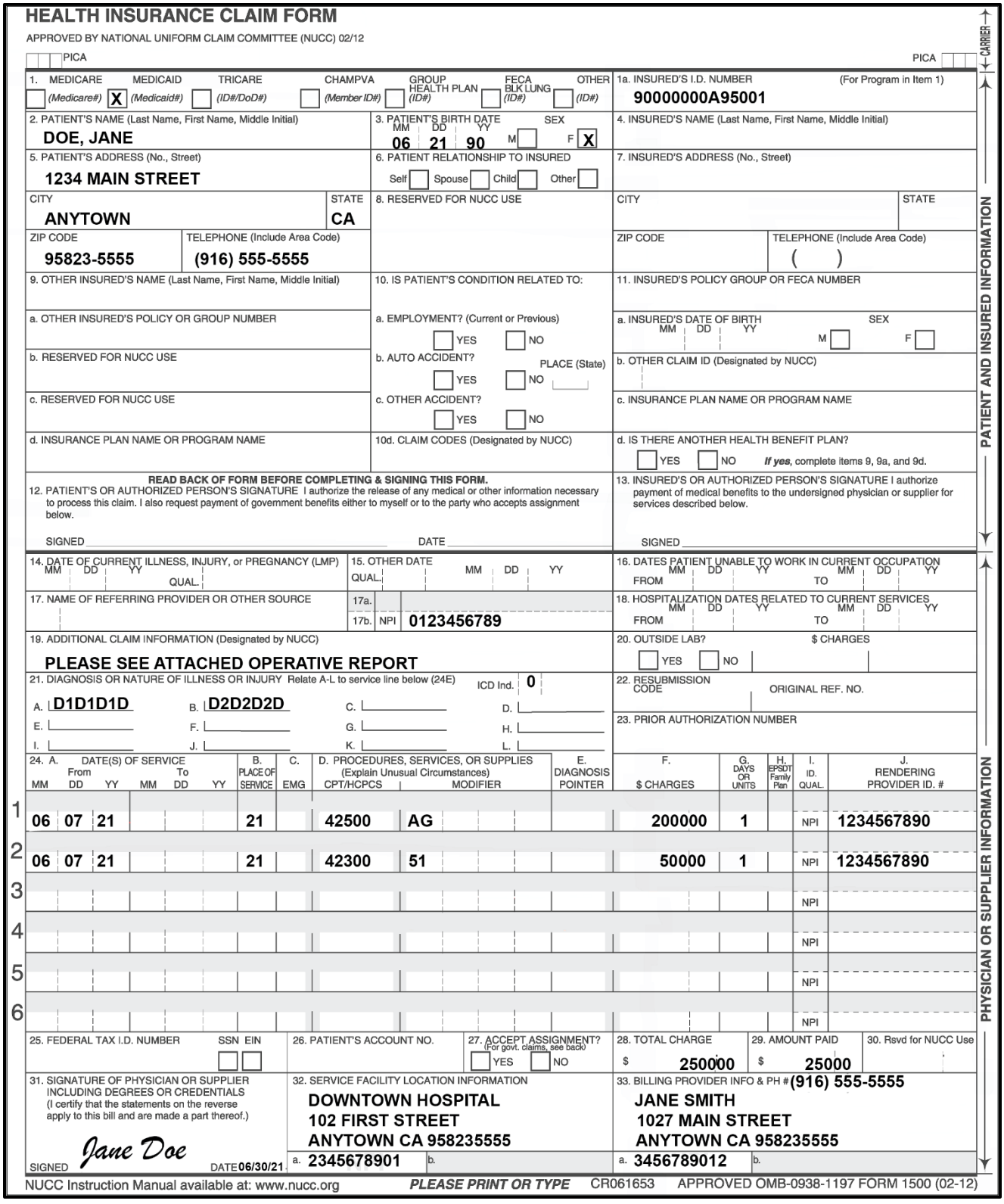
Box #	Field Name	Instructions	Billing Tip
28	Total Charge	Enter the full dollar amount for all services without the decimal point (.) or dollar sign ($). For example, $100 should be entered as “10000.”	None
29	Amount Paid	Enter the full dollar amount of payments(s) received from the Other Health Coverage (Box 11D) and/or patient’s Share of Cost (Box 10D), without the decimal point (.) or dollar sign ($).	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.	None
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.	An original signature is required on all paper claims. The signature must be written, 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.	Use the name and address of the facility where the services were rendered if other than a home or office. **Note:** Not required for clinical laboratories when billing for their own services.

Table of Field Descriptions for the CMS-1500 Claim Form, Continued

Box #	Field Name	Instructions	Billing Tip
32A	(blank)	Enter the NPI of the facility where the services were rendered.	None
32B	(blank)	Enter the Medi-Cal provider number for an atypical service facility.	None
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. **Note:** The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.	None
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.	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.

D CMS-1500 Claim Form

Page updated: January 2022



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [X] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [ ] (ID#)

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 MM DD YY: 06 21 90 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 MAIN STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE: 95823-5555 TELEPHONE (Include Area Code): (916) 555-5555

ZIP CODE TELEPHONE (Include Area 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) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] 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? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI 0123456789

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): PLEASE SEE ATTACHED OPERATIVE REPORT

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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.

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	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 06 07 21		21		42500	AG		200000	1		NPI	1234567890
2 06 07 21		21		42300	51		50000	1		NPI	1234567890
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 250000

29. AMOUNT PAID $ 25000

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 Jane Doe DATE 06/30/21

32. SERVICE FACILITY LOCATION INFORMATION

DOWNTOWN HOSPITAL
102 FIRST STREET
ANYTOWN CA 958235555

a. 2345678901 b.

33. BILLING PROVIDER INFO & PH # (916) 555-5555

JANE SMITH
1027 MAIN STREET
ANYTOWN CA 958235555

a. 3456789012 b.

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CARRIER

PATIENT AND INSURED INFORMATION

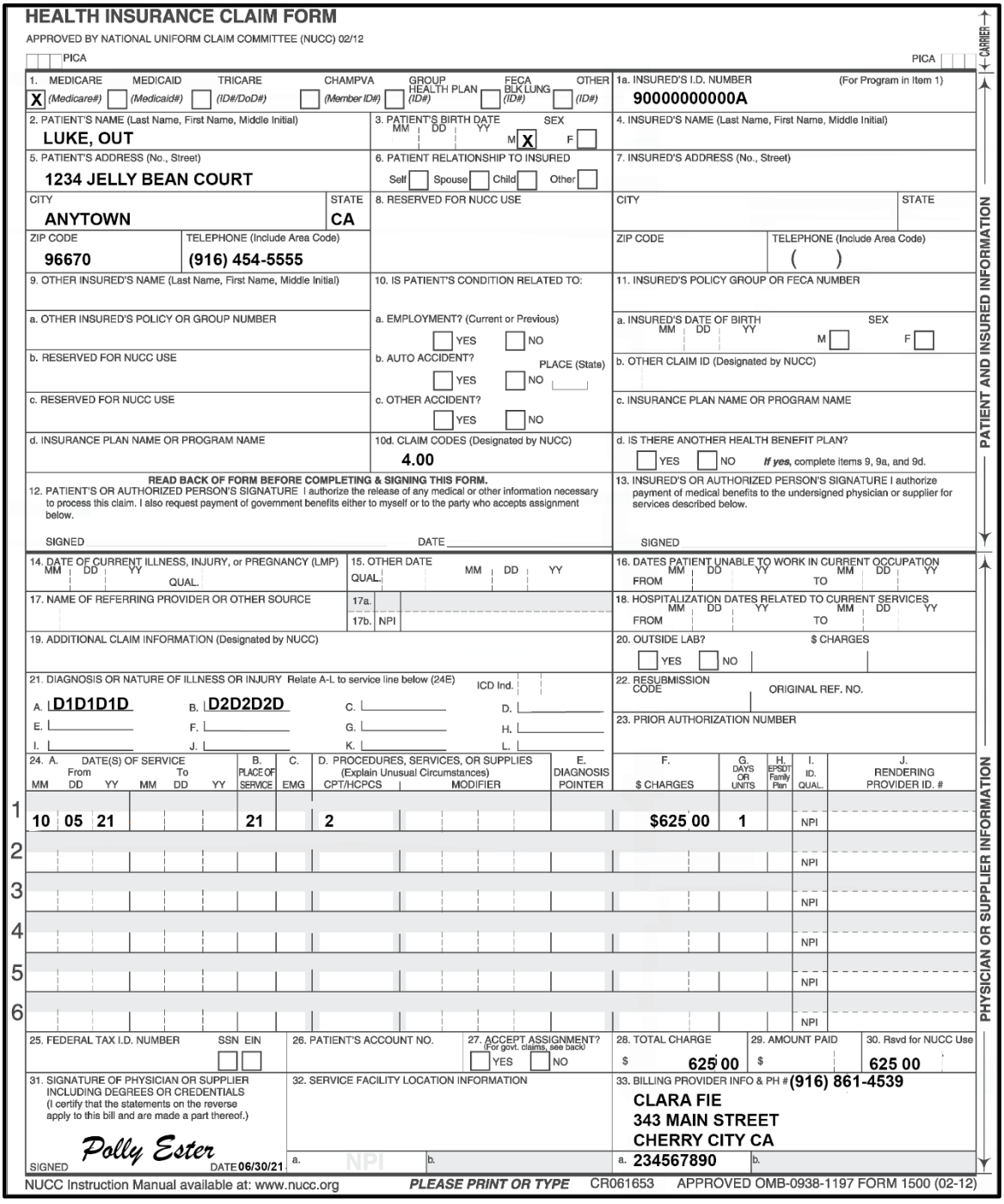
PHYSICIAN OR SUPPLIER INFORMATION

Sample: *CMS-1500* Claim Form

Learning Activity

What is wrong with this claim?

Identify 15 claim completion errors. See the Appendix for the Answer Key.



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE [X] (Medicare#) | MEDICAID [ ] (Medicaid#) | TRICARE [ ] (ID#/DoD#) | CHAMPVA [ ] (Member ID#) | GROUP HEALTH PLAN [ ] (ID#) | FECA BLK LUNG [ ] (ID#) | OTHER [ ] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000000A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LUKE, OUT

3. PATIENT'S BIRTH DATE MM DD YY | SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1234 JELLY BEAN COURT

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: ANYTOWN | STATE: CA

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: 96670 | TELEPHONE (Include Area Code): (916) 454-5555

ZIP CODE | TELEPHONE (Include Area 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) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC): 4.00

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes,* complete items 9, 9a, and 9d.

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. D1D1D1D B. D2D2D2D 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	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	10	05	21			21		2			$625 00	1		NPI	
2														NPI	
3														NPI	
4														NPI	
5														NPI	
6														NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ 625 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use 625 00

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.)

Polly Ester

SIGNED DATE 06/30/21

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # (916) 861-4539

CLARA FIE
343 MAIN STREET
CHERRY CITY CA

a. 234567890 b.

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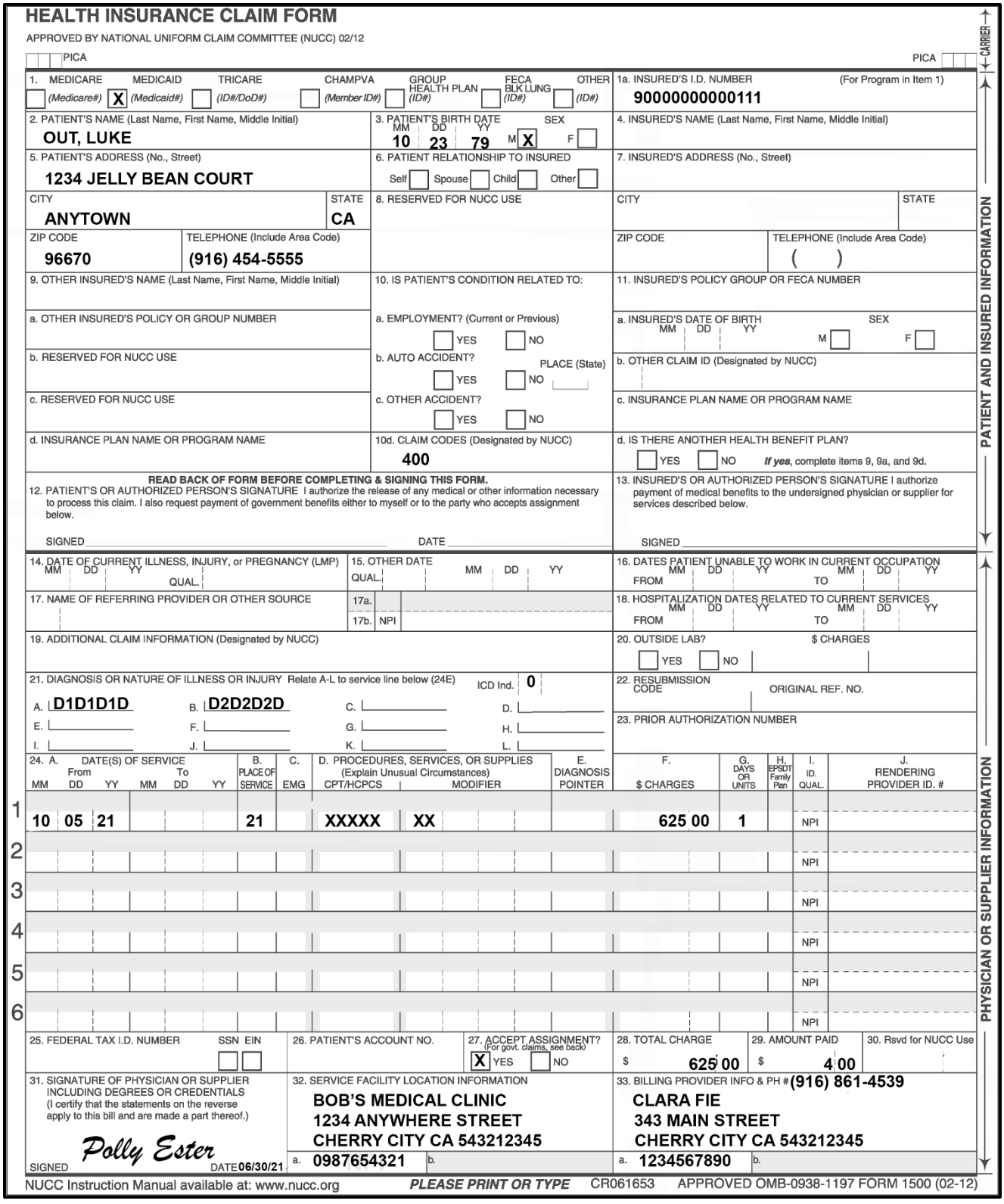
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample: Incorrect *CMS-1500* Claim Form

D CMS-1500 Claim Form

Page updated: January 2022



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) | MEDICAID [X] (Medicaid#) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 90000000000111

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): OUT, LUKE

3. PATIENT'S BIRTH DATE: 10 23 79 SEX: M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1234 JELLY BEAN COURT

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: CA

8. RESERVED FOR NUCC USE

CITY: STATE:

ZIP CODE: 96670 TELEPHONE (Include Area Code): (916) 454-5555

ZIP CODE: TELEPHONE (Include Area 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) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. OTHER CLAIM ID (Designated by NUCC):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC): 400

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, complete items 9, 9a, and 9d.

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 MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

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.

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	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 10 05 21		21		XXXXX	XX		625 00	1		NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 625 00

29. AMOUNT PAID $ 4 00

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 Polly Ester DATE 06/30/21

32. SERVICE FACILITY LOCATION INFORMATION

BOB'S MEDICAL CLINIC
1234 ANYWHERE STREET
CHERRY CITY CA 543212345

a. 0987654321 b.

33. BILLING PROVIDER INFO & PH # (916) 861-4539

CLARA FIE
343 MAIN STREET
CHERRY CITY CA 543212345

a. 1234567890 b.

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Sample: Corrected *CMS-1500* Claim Form

Resource Information

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)

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 required by the Medi-Cal program.

Module Objectives

- Identify the section in the provider manual related to *UB-04* claim form completion
- Outline Diagnosis-Related Groups (DRG) reimbursement requirements
- Introduce general completion and submission billing guidelines for the *UB-04* claim form
- Understand the differences between inpatient and outpatient services claim completion on a *UB-04* claim form
- Discuss common claim completion errors (billing tips)
- Participate in an interactive claim completion learning activity.

Acronyms

A list of current acronyms is located in the *Appendix* section of each complete 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 for inpatient providers to 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 (diagnosis ip) 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 (hospital dir) 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.

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 (CBAS).

After a *UB-04* claim has been submitted, it must be received by the California Medicaid Management Information System (CA-MMIS) 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 Methods

Paper Format

Providers are required to purchase *UB-04* 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

- Bill in the Medi-Cal format. Follow claim form completion instructions outlined in the *UB-04 Completion: Inpatient Services* section (ub comp ip) or *UB-04 Completion: Outpatient Services* section (ub comp op).
- 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.
- Appropriate modifiers must be used when billing for surgical, pathology, radiology and some medicine codes.

Claim Reimbursement Guidelines

Claim Submission Timeliness Requirements

Original Medi-Cal or California Children's Services (CCS) claims must be received by the California Medicaid Management Information System (California MMIS) Fiscal Intermediary within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit.

Full Reimbursement Policy

Reimbursement Deadlines

If the Date of Service (DOS) falls within this month:	Then claims must be received by 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 California MMIS Fiscal Intermediary without a valid delay reason will be reimbursed at a reduced rate according to the date in which the claim was received.

Partial reimbursement rates are paid as follows:

- 100% Reimbursement from 0 to the end of 6 months.
- 75% Reimbursement from 7 months to the end of 9 months.
- 50% Reimbursement from 10 months to the end of a year.

Delay Reason Codes

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 reason for late claim submission, these exceptions also have time limits. Refer to the *UB-04 Submission and Timeliness Instructions* section (ub sub) of the Part 2 provider manual.

Table of Delay Reason Codes and Descriptions

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 (eg. theft); attach documentation justifying delay reason
15	Natural disaster

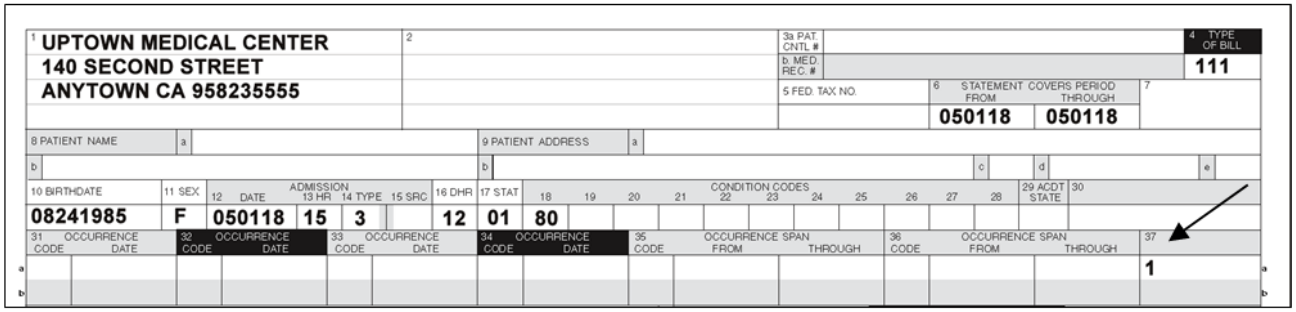
Note: To receive full payment, providers must attach documentation justifying the delay reason. Providers billing with a delay reason code without the required attachments will be denied or reimbursed at a reduced rate.

Billing Notice

Most providers may no longer bill Medi-Cal or CCS using a recipient's Social Security Number (SSN). Claims submitted with a recipient's SSN will be denied.

UB-04 Delay Reason Code Claim Example

Place the delay reason code in the unlabeled Box 37.



Claims Over One Year

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

- Third party decision 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 California MMIS Fiscal Intermediary at the following address:

Attn: Over One Year Claims Unit
California MMIS Fiscal Intermediary
P.O. Box 13029
Sacramento, CA 95813-4029

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.

Refer to the appropriate Part 2 provider manual section: *UB-04 Submission and Timeliness Instructions* (ub sub).

Form Completion Instructions

- Handwritten claims should be printed neatly using black ballpoint pen only. Do not use red pencils or red ink ballpoint pens.
- 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 FI 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.
- Ensure that a valid CPT/HCPCS code is used for the date of service. In addition, make sure the revenue code is valid and on file.
- 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 Format

Most claims for inpatient services can also be submitted through Computer Media Claims (CMC). For CMC ordering and enrollment information, refer to the CMC sections (cmc and cmc enroll) of the Part 1 provider manual.

The following guidelines apply to claim forms submitted by electronically.

The method of submitting claims electronically is referred to as CMC submission, and 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.

Submission Instructions

- Claims may be submitted electronically via CMC telecommunications (modem) or Medi-Cal website (*www.medi-cal.ca.gov*).
- Claims requiring hard copy attachments may be billed electronically.
- CMC claims requiring 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. Each ACF has a unique number that must be entered on the CMC in the appropriate field in order for the CMC to match the ACF.

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 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:

California MMIS Fiscal Intermediary
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

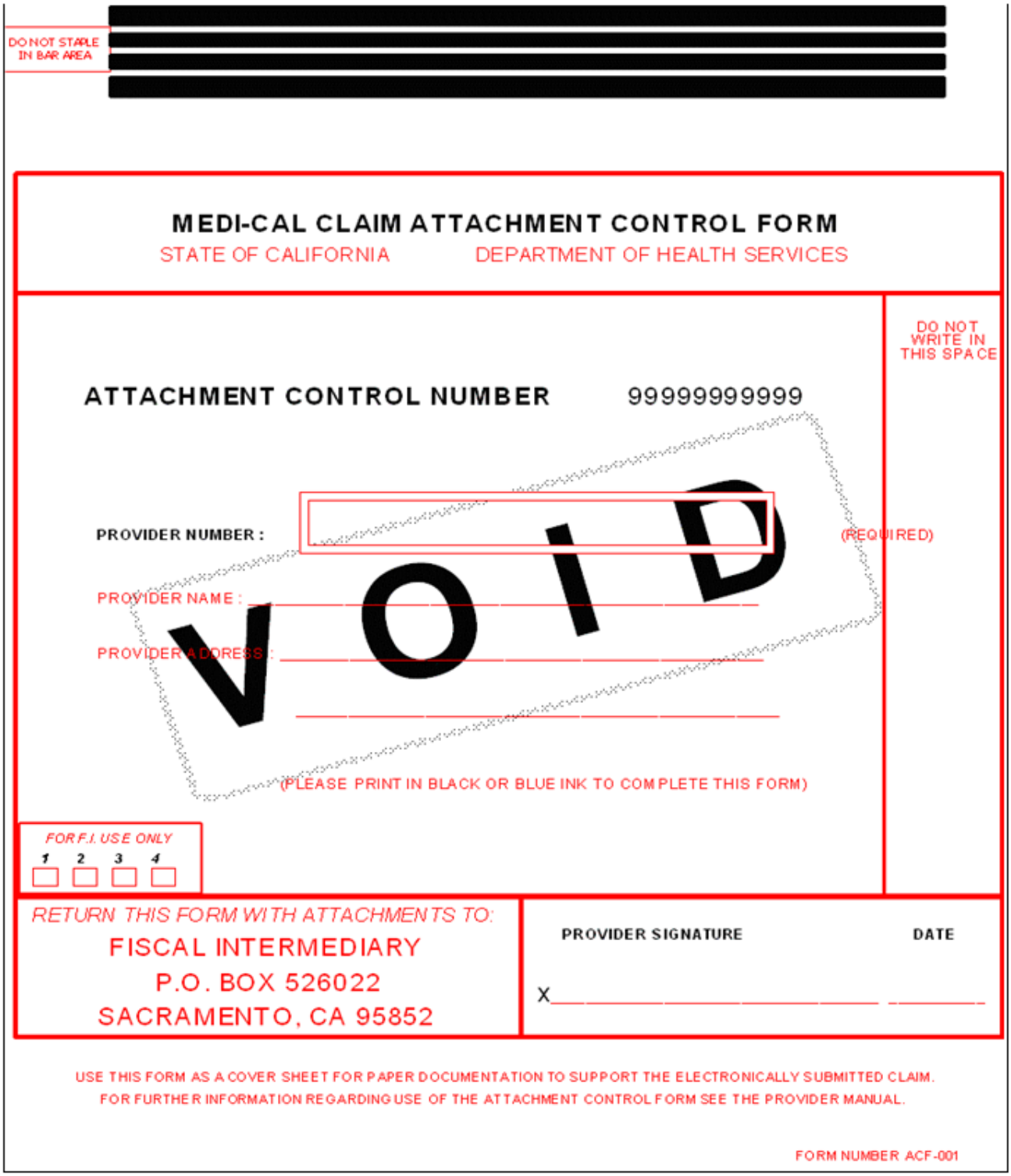
To place an order for ACFs or reorder forms, follow the instructions below:

- 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) of the Part 2 provider manual or visit the Medi-Cal website (*www.medi-cal.ca.gov*).

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

Sample Medi-Cal Claim Attachment Control Form



DO NOT STAPLE IN BAR AREA

[redacted]

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

DO NOT WRITE IN THIS SPACE

ATTACHMENT CONTROL NUMBER 99999999999

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

Sample ACF Rejection Letter

California MMIS
Fiscal Intermediary

P.O. Box 13029
Sacramento, CA 95813-4029

1.800.541.5555

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 Care Services (DHCS) 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: California MMIS 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 (TSC) at 1-800-541-5555.

Sincerely,

California Medicaid Management Information System Fiscal Intermediary

UB-04 Claim Form Completion

UB-04 Claim Form

The *UB-04* claim form is a national form; however, many fields are not required by Medi-Cal. Items described as “Not required by Medi-Cal” may be completed for other payers, but are not recognized by Medi-Cal claims processing system.

The information presented in this module focuses on the claim form fields that apply to Medi-Cal claims.

Sample Partial *UB-04* Claim Form

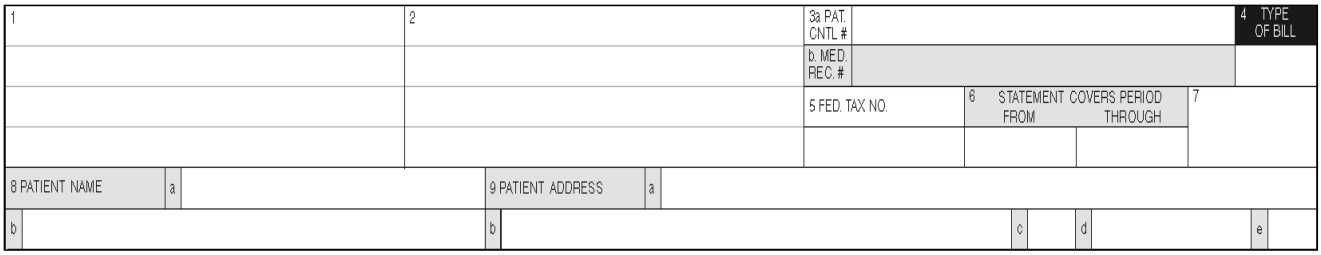


Table of *UB-04* Claim Form Fields 1 thru 6

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. **Note:** The nine-digit ZIP code entered in this box must match the billing provider’s ZIP code on file for claims to be reimbursed correctly.
3A	Patient Control Number	*(Optional Field)* 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 *Remittance Advice Detail* (RAD).
3B	Medical Record Number	*Not Required (for Medi-Cal)* Use Box 3a to enter a patient control number.

Table of *UB-04* Claim Form Fields 1 thru 6 (continued)

Box #	Field Name	Instructions
4	Type of Bill	Required (for Medi-Cal) Enter the appropriate three-character type of bill code as specified in the National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual. **Note:** For subacute services, specify the appropriate Place of Service and use modifier U2 (Outpatient Services). **Billing Tip:** The type of bill code includes a two-digit facility type code and a one-digit claim frequency code.
6	Statement Covers Period (From-Through)	**Outpatient Claims**: Not required **Inpatient Claims**: 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 THROUGH box, even though this date is not reimbursable (unless the day of discharge is the date of admission). **Note:** For “From-Through” billing instructions, refer to the UB-04 Special Billing Instructions for Inpatient Services section (ub spec ip) in the Part 2 provider manual.

Sample Partial *UB-04* Claim Form

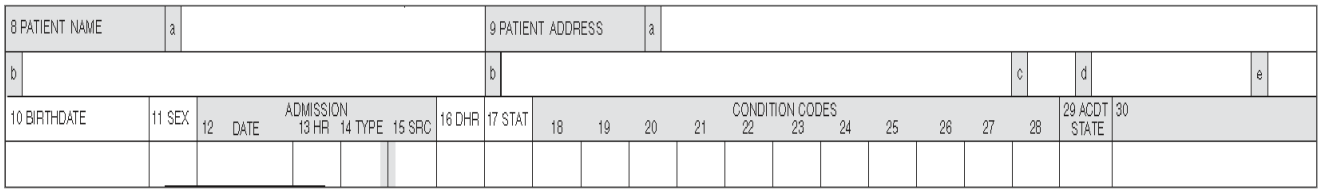


Table of *UB-04* Claim Form Fields 8b and 10

Box #	Field Name	Instructions
8B	Patient Name	Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases. **Newborn Infant:** 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" (for example, JONES BABY GIRL). **Billing Tip:** 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) on separate claims. Enter infant's date of birth/sex in boxes 10 and 11. Enter the mother's name in the *Insured's Name* field (Box 58) and enter "03" (Child) in the *Patient's Relationship to Insured* field (Box 59). **Organ Donors:** 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 *Insured's Name* field (Box 58) and enter "11" (Donor) in the *Patient's Relationship to Insured* field (Box 59).
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). **Note:** If the recipient's full date of birth is not available, enter the year preceded on 0101. For newborns and organ donors, see item 8B).

Table of *UB-04* Claim Form Fields 11 thru 14

Box #	Field Name	Instructions
11	Sex	Enter the capital letter “M” for male or “F” for female. **Billing Tip:** When submitting a claim for a newborn infant using the mother’s ID number, enter the infant’s gender in Field 11.
12 thru 13	Admission Date and Hour	**Outpatient Claims:** *Not required* **Inpatient Claims:** 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. **Billing Tip:** The admit time of 1:45 p.m. will be entered on the claim as 13.
14	Admission Type	**Outpatient Claims:** 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. **Inpatient Claims:** Enter the numeric code indicating the necessity for admission to the hospital. • Patient Admission Status is Emergency, use code 1 • Patient Admission Status is Elective, use code 3 • Patient Admission Status is Newborn, use code 4 **Note:** If the delivery was outside the hospital, use admit type code “1” (emergency) in the Type of Admission and admission source code “4” (extramural birth) in the Source of Admission field (Box 15).

Table of *UB-04* Claim Form Fields 15 thru 17

Box #	Field Name	Instructions
15	Admission Source	**Outpatient Claims:** *Not required* **Inpatient Claims:** 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. • Transfer Source is from a hospital, use code 4 • Transfer Source is from a Skilled Nursing Facility (SNF), use code 5 • Transfer Source is from another health care facility, use code 6. When the type of admission code in Box 14 is "4" (newborn [used by Medi-Cal only; baby born outside hospital], submit claim with source of admission code "4" in Box 15 and appropriate revenue code in Box 42.
16	Discharge Hour	**Outpatient Claims:** *Not required* **Inpatient Claims:** Enter the discharge hour as follows: • Do not include the minutes • Convert discharge hour to 24-hour (00-23) format, e.g. 3:00 p.m. = 15. **Note:** If the patient has not been discharged, leave this field blank.
17	Status	**Outpatient Claims:** *Not required* **Inpatient Claims:** Enter the numeric code explaining patient status as of the "THROUGH" date indicated in (Box 6) under *Statement Covers Period.* (The listed codes below are only a few examples of the codes utilized to describe patient status). Refer to billing instructions in the *UB-04 Completion: Inpatient Services* section (ub comp ip) of the Part 2 provider manual for status codes and explanations. • Patient Status is Discharged to Home, use code 01 • Patient Status is Expired, use code 20 • Patient Status is Still a Patient, use code 30

Table of *UB-04* Claim Form Fields 18 thru 24

Box #	Field Name	Instructions
18 thru 24	Condition Codes	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. **Billing Tip:** Enter code "81" when billing for emergency services, or the claim may be reduced or denied. An Emergency Certification Statement must be attached to the claim or entered in the *Remarks* field (Box 80). **Note:** Providers may include codes accepted by other payers. The claims processing system recognizes condition codes entered in Boxes 18 thru 24 only.

Sample Partial *UB-04* Claim Form

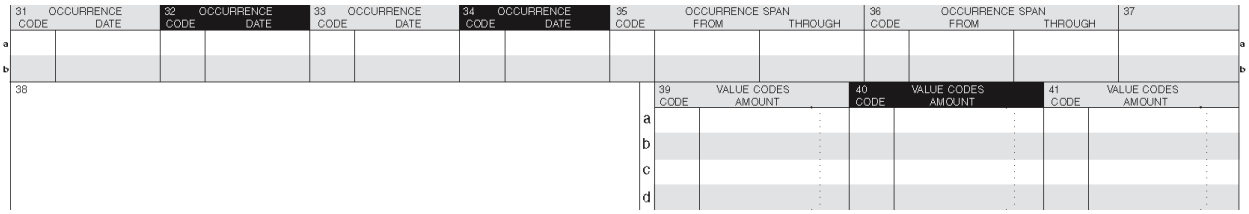
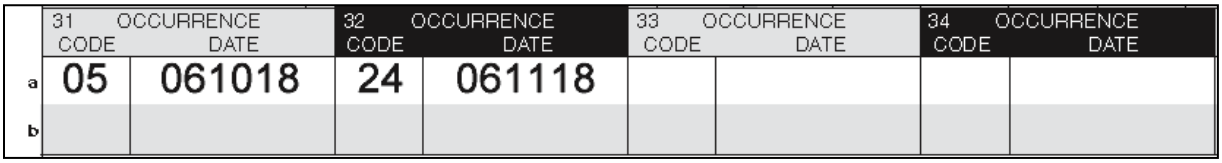


Table of *UB-04* Claim Form Fields 31 thru 34A and B

Box #	Field Name	Instructions
31 thru 34 A and B	Occurrence Codes and Dates	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. **See example below.** 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 thru 34. The claims processing system will ignore all codes not applicable to Medi-Cal. Use these codes if the accident or injury was non-employment related: • Code 01: Accident/medical coverage • Code 02: No fault insurance involved – including auto accident/other • Code 03: Accident/tort liability • Code 05: Accident/no medical or liability coverage • Code 06: Crime victim Enter the accident/injury date in corresponding box (6-digit format MMDDYY). **Note:** Enter code “04” (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related. **Outpatient Claims:** Discharge date is not applicable. **Inpatient Claims:** Discharge Date: Enter occurrence code “42” and the date of hospital discharge (in six-digit format) when the date of discharge is different from the “THROUGH” date in Box 6.

Example: 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.

Sample Partial *UB-04* Claim Form (Box 31 thru 34A and B)



	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE
a	05	061018	24	061118				
b								

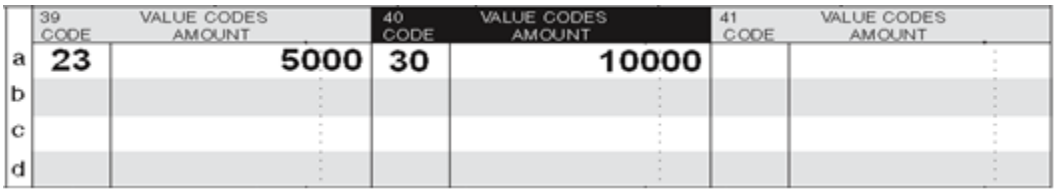
Table of *UB-04* Claim Form Fields 37A

Box #	Field Name	Instructions
37A	Unlabeled (use for delay reason codes)	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. See “Table of Delay Reason Codes and Required Documentation” below. **Note:** Documentation justifying the delay reason must be attached to the claim to receive full payment. **Billing Tip:** Providers billing with delay reason “11” without an attachment will either receive reimbursement at a reduced rate or a claim denial. **For hospitals that are not reimbursed according to the diagnosis-related groups (DRG) model:** Providers must use claim frequency code “5” in the *Type of Bill* field (Box 4) of the claim when adding a new ancillary code to a previous stay, if the original stay was already billed.

Table of Delay Reason Codes and Required Documentation

Code#	Description	Documentation
1	Proof of Eligibility unknown or unavailable	Remarks/Attachment
3	Authorization delays	Remarks
4	Delay in certifying provider	Remarks
5	Delay in supplying billing forms	Remarks
6	Delay in delivery of custom-made appliances	Remarks
7	Third party processing delays	Attachment
10	Administrative delay in prior approval process (decision appeals)	Attachment
11	Other (no reason)	None *
11	Other (theft, sabotage)	Attachment *
15	Natural disaster	Attachment

Sample Partial *UB-04* Claim Form



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

Table of *UB-04* Claim Form Fields 39 thru 41 A thru D

Box #	Field Name	Instructions
39 thru 41 A thru D	Value Codes and Amounts (Patient's Share of Cost)	Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. If billing for two value codes "30" (accepted by another payer) and "23" (accepted by Medi-Cal), enter "23" in Box 39A and "30" in Box 40A. If the SOC collect/obligated is $50, enter 5000, not 50. 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 thru 41. The claims processing system ignores all codes not applicable to Medi-Cal.

Notes:

Table of *UB-04* Claim Form Fields 39 thru 41 A thru D (continued)

Box #	Field Name	Instructions
39 thru 41 A thru D (continued)	Value Codes and Amounts (Patient's Share of Cost)	Example: Enter code "23" and amount of the patient's SOC for the procedure or service, if applicable. Do not enter a decimal point (.), dollar sign ($), positive (+) or negative (-) sign. Enter full dollar amount and cents, even if the amount is even. (For example, if billing for $100, enter 10000, not 100). For more information about Share of Cost, see the *Share of Cost: UB-04 for Inpatient Services* or *UB-04 Outpatient Services* section of the Part 2 provider manual. If the SOC collected/obligated is $50, enter 5000 not 50. **Billing Tip:** Value code information is required for Medicare/Medi-Cal crossover claims.

Sample Partial *UB-04* Claim Form

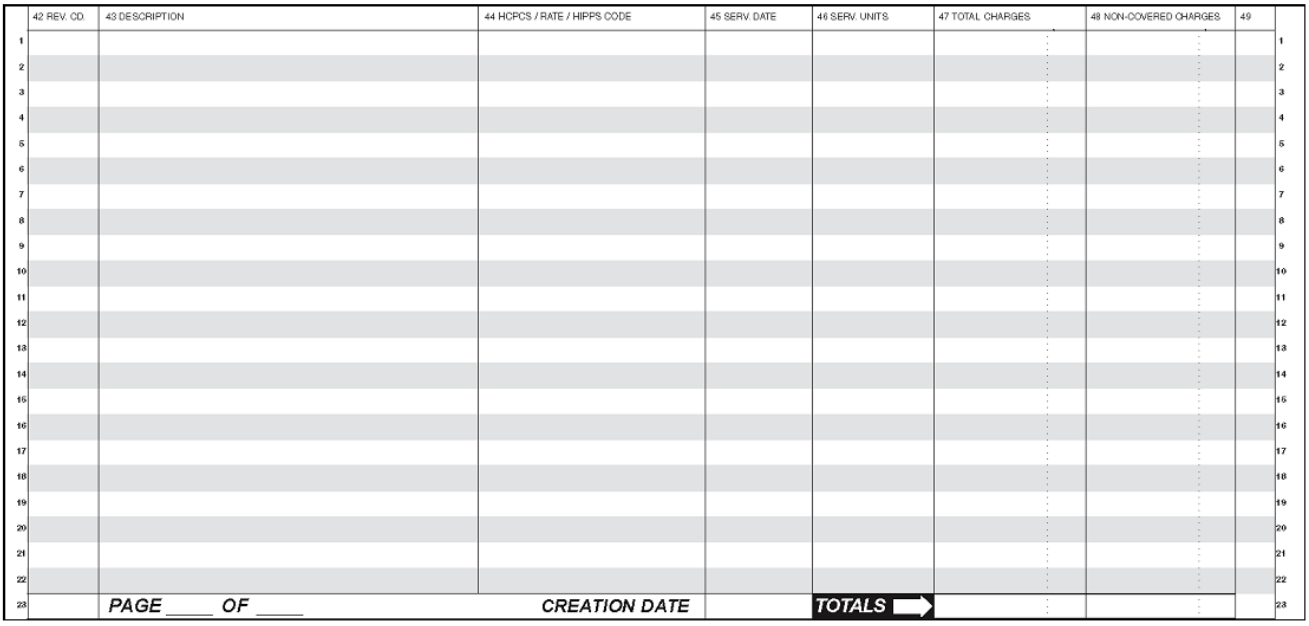


Table of *UB-04* Claim Form Fields 42 thru 43

Box #	Field Name	Instructions
42	Revenue Code	**Outpatient Claims:** Revenue codes are required (for instance, for organ procurement) doe select OP billing. Specific instructions are included in select provider manual sections. **Inpatient Claims:** Enter the appropriate revenue or ancillary code. Refer to the *Revenue Codes for Inpatient Services* section (rev cd ip) in the appropriate Part 2 provider manual. Ancillary codes are listed in the *Ancillary Codes* section (ancil cod) of the Part 2 provider manual. **Billing Tip:** 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 Box 47, line 23.
43	Description	**Outpatient Claims:** Information entered into this field will help separate and identify the descriptions of each service. The description must identify the service code indicated in the *HCPCS/Rate/HIPPS Code* field (Box 44). This field is optional, except when billing for physician-administered drugs. Refer to the *Physician-Administered Drugs – NDC UB-04 Billing Instructions* section (physician ndc ub) of the Part 2 provider manual for more information. **Inpatient Claims:** Enter the description of the revenue or ancillary code listed in the *Revenue Code* field (Box 42). **Note:** If there are multiple pages of the claim, enter the page numbers on line 23 in this field.

Sample Partial *UB-04* Claim Form

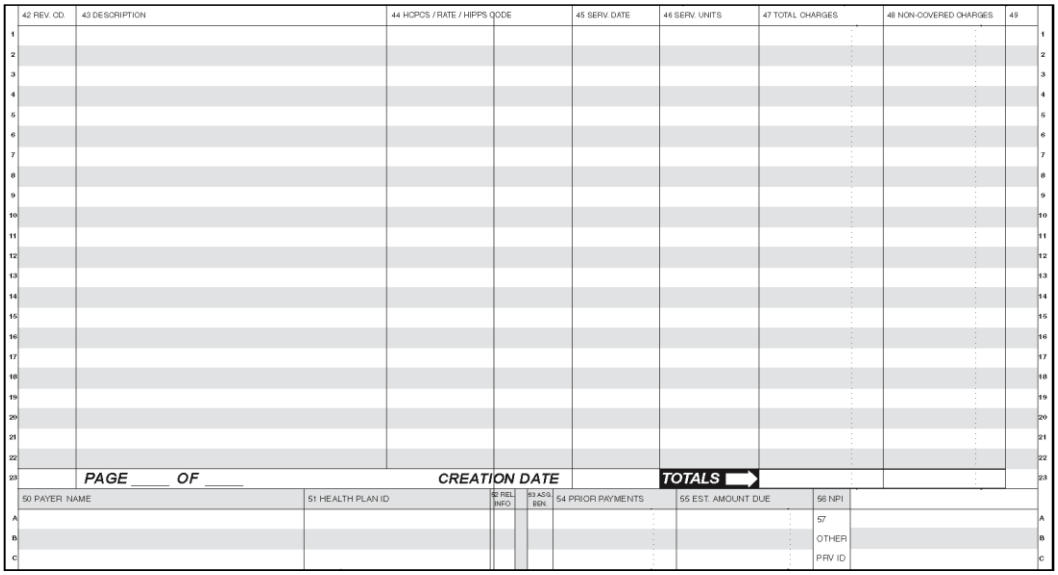


Table of *UB-04* Claim Form Field 44

Box #	Field Name	Instructions
44	HCPCS/Rate	**Outpatient Claims:** 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. 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 codes are listed in the *TAR & Non-Benefit List: Codes (10000 thru 99999)* sections in the appropriate Part 2 manual. All modifiers must be billed immediately following the HCPCS code in the *HCPCS/Rate* field (Box 44) with no spaces. Up to four modifiers may be entered on the outpatient *UB-04* claim form. **Inpatient Claims:** *Not required*

Sample UB-04 form showing Box 44 with HCPCS code and Modifier Placement

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1		EMERGENCY ROOM USE	Z7502XXXXXXXX	060218	2	230000
2						
3						
4						

Table of *UB-04* Claim Form Fields 45 thru 47

Box #	Field Name	Instructions
45	Service Date	**Outpatient Claims:** Enter the date the service was rendered in six-digit format. **Inpatient Claims:** *Not required by Medi-Cal* **Billing Tip:** For "From-Through" billing instructions, see the *UB-04 Special Billing Instructions for Outpatient Services* section (ub spec op).
46	Service Units	**Outpatient Claims:** 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. **Billing Tip:** Although *Service Units* is a seven-digit field, Medi-Cal only allows two digits. **Inpatient Claims:** 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.
47	Total Charges	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"). Enter the total charge for all services on the last line or on line 23. Enter "001" in *Revenue Code* field (Box 42, line 23) to indicate this is the total charge line. **Note:** Up to 22 lines of data (fields 42 thru 49) can be entered. It is acceptable to skip lines. **Outpatient Claims:** 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 thru 49), using a black ballpoint pen.

Table of *UB-04* Claim Form Fields 50A thru C and 54A thru C

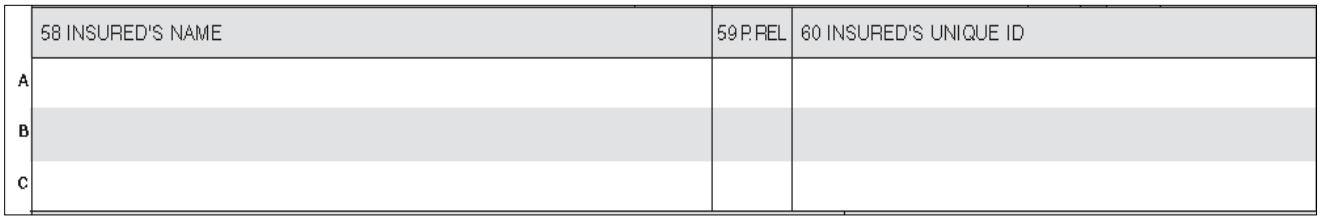
Box #	Field Name	Instructions
50A thru C	Payer Name	**Outpatient Claims:** Enter “O/P MEDI-CAL” to indicate outpatient claim and payer. **Inpatient Claims:** Enter “I/P MEDI-CAL” to indicate inpatient claim and payer. **Note:** If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing Medi-Cal. **Billing Tip:** When completing Boxes 50 thru 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 thru 65 (excluding Box 56) should be entered on Line A.
54A thru C	Prior Payments	Leave blank if not applicable. Enter the full dollar amount of payment received from OHC, on line A or B that corresponds with OHC in the *Payer* field (Box 50). Do not enter a decimal point (.), dollar sign ($), plus (+) or minus (-) sign. **Note:** For instructions about completing this field for Medicare/Medi-Cal recipients, refer to the *Medicare/Medi-Cal Crossover Claims: UB-04* section (medi cr ub) in the provider manual.

Table of *UB-04* Claim Form Fields 55A thru C, thru 57A thru C

Box #	Field Name	Instructions
55A thru C	Estimated Amount Due (Net amount billed)	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 ($). Example: Patient's SOC *Value Codes Amount* and/or OHC *Prior Payments.*
56	NPI	Enter the appropriate 10-digit National Provider Identifier (NPI) number.
57A thru C	Other Provider ID	Not required by Medi-Cal for inpatient providers. Outpatient: Enter the Medi-Cal provider number, corresponding to the information on lines A, B or C. **Note:** 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.

Notes:

Sample Partial *UB-04* Claim Form



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

Table of *UB-04* Claim Form Fields 58A thru C, thru 60A thru C

Box #	Field Name	Instructions
58A thru C	Insured's Name	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 *Patient's Relationship to Insured* field (Box 59). **Note:** This field is not required by Medi-Cal except under these circumstances.
59A thru C	Patient's Relationship to Insured	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]). **Note:** This field is not required by Medi-Cal except under these circumstances.
60A thru C	Insured's Unique ID	Enter the recipient's 14-digit ID number as it appears on the Benefits Identification Card (BIC) or paper Medi-Cal card. When submitting a claim for a newborn infant for the month of birth or the following month, enter the mother's ID number in this field. (For more information, see Item 8B). **Note:** Medi-Cal does not accept Health Insurance Claim (HIC) numbers.

Sample Partial *UB-04* Claim Form

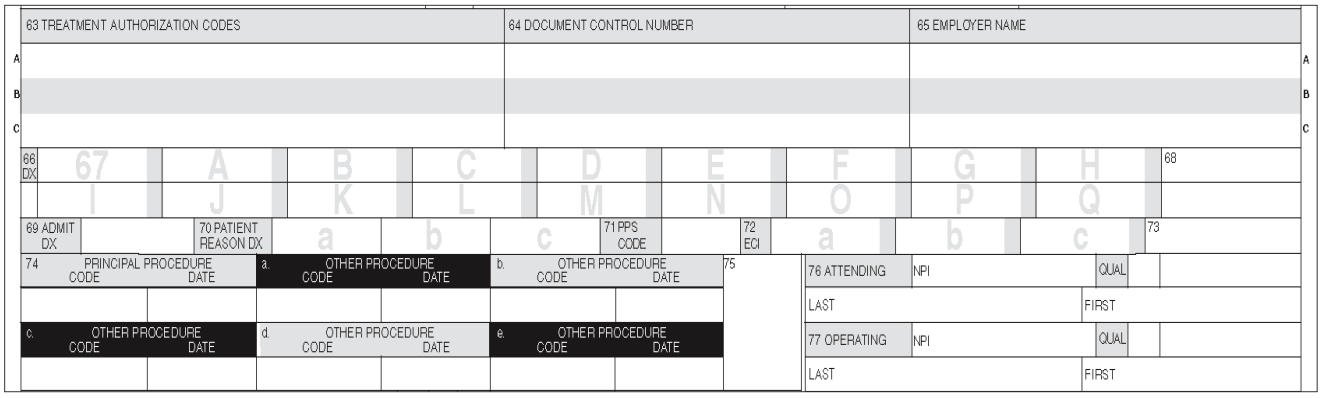


Table of *UB-04* Claim Form Fields 63A thru C, thru 66

Box #	Field Name	Instructions
63A thru C	Treatment Authorization Codes	For services requiring a *Treatment Authorization Request* (TAR), enter the 11-digit TAR Control Number (TCN). It is not necessary to attach a copy of the TAR. Recipient information on the claim must the match TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TCN can cover services billed on any one claim. **Inpatient Claims:** 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 *Remarks* field [Box 80].) **Billing Tip:** TAR and Non-TAR procedures should not be combined on the same claim.
66	Diagnosis Code Header	Claims with a diagnosis code in Box 67 must include the ICD indicator “0” for ICD-10-CM diagnosis codes, effective October 1, 2015.

Table of *UB-04* Claim Form Fields 67 and 67A

Box #	Field Name	Instructions
67	Unlabeled (Primary Diagnosis Code)	Include all letters and numbers of the ICD-10-CM diagnosis code to the highest level of specificity (when possible) including fourth through seventh digits if present for the primary diagnosis code. Do not include a decimal point. The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67A. Present on Admission (POA) indicator. Each diagnosis code may require a POA indicator. 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.
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. **Note:** Paper claims accommodate up to 18 diagnosis codes.

Table of *UB-04* Claim Form Field 74 and 74A thru E

Box #	Field Name	Instructions
74	Principle Procedure Code and Date	**Outpatient Claims:** Not required by Medi-Cal **Inpatient Claims:** 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. **Billing Tip:** Inpatient providers must enter ICD-10-PCS code in this field (not CPT-4/HCPCS surgical procedure code).
74A thru E	Other Procedure Codes and Dates	Outpatient Claims: *Not required* Inpatient Claims: Enter the appropriate ICD-10-PCS code, identifying the secondary medical or surgical procedure, without period or spaces between the numbers. **Note:** For OB vaginal or cesarean delivery and transplants, enter a suitable ICD-10-PCS code in either Box 74 or 74A thru E.

Sample Partial *UB-04* Claim Form

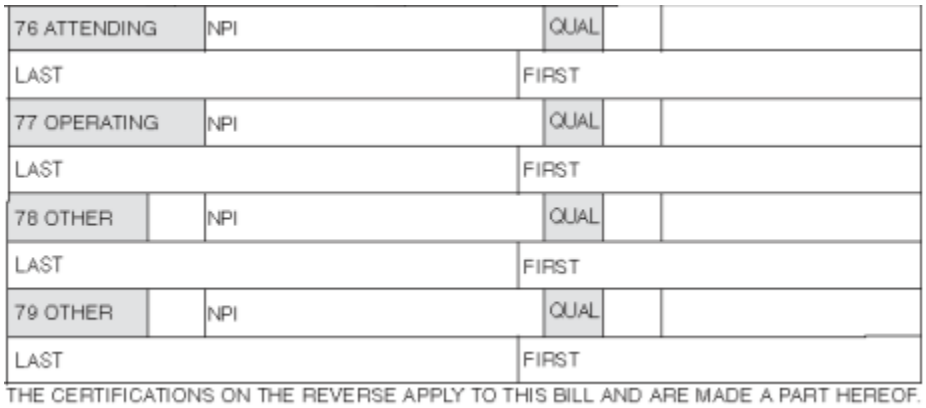


Table of *UB-04* Claim Form Field 76

Box #	Field Name	Instructions
76	Attending	**Outpatient Claims:** Enter the referring or prescribing physician's NPI in the first box. This field is mandatory for radiologists. If the physician is not a Medi-Cal provider, enter the state license number. Do not use a group provider number. Referring or prescribing physician's first and last names are not required by Medi-Cal. **Billing Tip:** For atypical referring or prescribing physicians, enter the Medicaid Identifier "1D" in the *Qual ID* box and enter the Medi-Cal provider number next to it. **Inpatient Claims:** Enter the attending physician's NPI in the first box. Do not enter a group number. The attending physician's first and last name is not required. **Billing Tip:** For inpatient claims, do not enter the operating or admitting physician NPI in this field.

Table of *UB-04* Claim Form Fields 77 thru 78

Box #	Field Name	Instructions
77	Operating	**Outpatient Claims:** Enter the NPI of the facility in which the recipient resides or the physician providing services. Only one rendering provider number may be entered per claim. Do not use a group number or state license number. **Billing Tip:** For atypical rendering physicians, enter the Medicaid Identifier "1D" in the *Qual ID* box and the Medi-Cal Provider number next to it. Do not use a group provider number. **Inpatient Claims:** Enter the operating physician's NPI in the first box. Do not enter a group provider number. The operating physician's first and last name is not required by Medi-Cal.
78	Other	**Outpatient Claims:** *Not required* **Inpatient Claims:** Enter the admitting physician's NPI in the first box. Do not enter a group provider number. The admitting physician's first and last name is not required by Medi-Cal.

Notes:

Sample Partial *UB-04* Claim Form

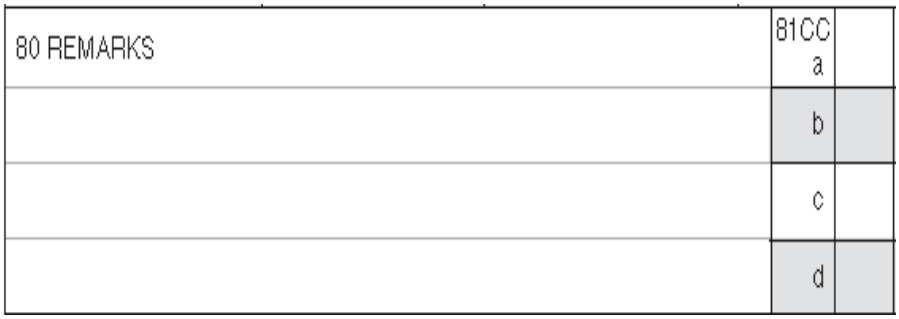


Table of *UB-04* Claim Form Field 80

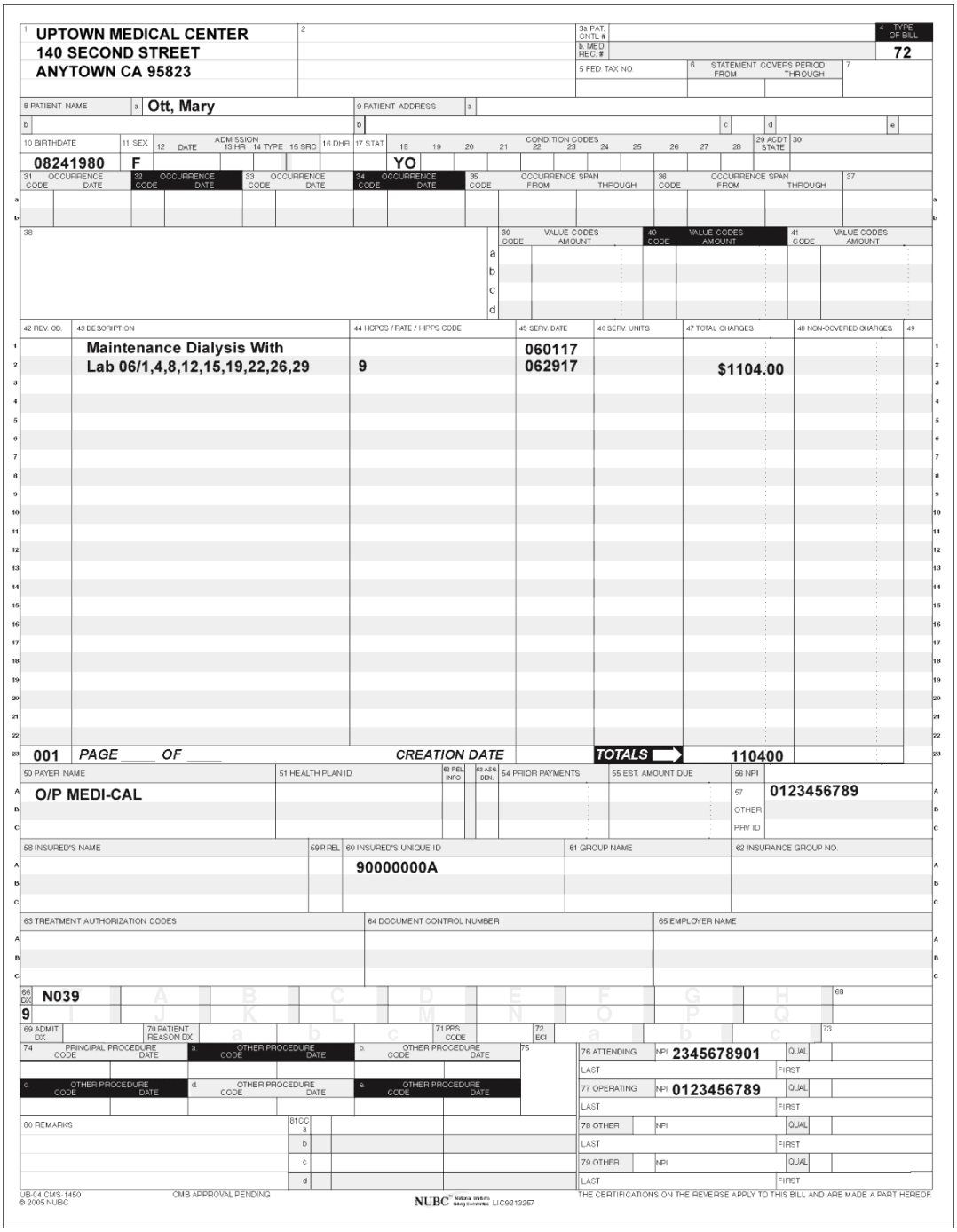
Box #	Field Name	Instructions
80	Remarks	Use this area for procedures that require additional information, justification or an *Emergency Certification Statement.* This statement must be signed and dated by the provider and must be supported by a physician, podiatrist or dentist's statement describing 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 *Emergency Certification Statement* will not fit in this area, attach the statement to the claim. **Billing Tips**: 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. • "By Report" claim submissions do not always require an attachment. For some procedures, entering information in the *Remarks* field (Box 80) of the claim may be sufficient. • Eligibility Verification Confirmation (EVC) numbers, are not required as attachments unless the claim is over 1 year old.

Learning Activity

What is wrong with this claim?

Identify 10 claim completion errors. See Appendix for the Answer Key.

Incorrect Claim Example



1 UPTOWN MEDICAL CENTER
140 SECOND STREET
ANYTOWN CA 95823

2

3a PAT. CNTL #
b MED REC. #

4 TYPE OF BILL: 72

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD: FROM / THROUGH

7

8 PATIENT NAME: a Ott, Mary

9 PATIENT ADDRESS

10 BIRTHDATE: 08241980

11 SEX: F

12 ADMISSION DATE / 13 HR / 14 TYPE / 15 SRC

16 DHR

17 STAT: YO

18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28

29 ACDT STATE

30

31 OCCURRENCE CODE / DATE

32 OCCURRENCE CODE / DATE

33 OCCURRENCE CODE / DATE

34 OCCURRENCE CODE / DATE

35 OCCURRENCE SPAN CODE / FROM / THROUGH

36 OCCURRENCE SPAN CODE / FROM / THROUGH

37

38

39 VALUE CODES CODE / AMOUNT

40 VALUE CODES CODE / AMOUNT

41 VALUE CODES CODE / AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	Maintenance Dialysis With Lab 06/1,4,8,12,15,19,22,26,29	9	060117 062917		$1104.00		
001	PAGE ____ OF ____	CREATION DATE		TOTALS	110400		

50 PAYER NAME: O/P MEDI-CAL

51 HEALTH PLAN ID

52 REL INFO

53 ASG BEN.

54 PRIOR PAYMENTS

55 EST. AMOUNT DUE

56 NPI

57 OTHER PRV ID: 0123456789

58 INSURED'S NAME

59 P REL

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 DX: N039
9

67 A B C D E F G H I J K L M N O P Q

68

69 ADMIT DX

70 PATIENT REASON DX a b c

71 PPS CODE

72 ECI a b c

73

74 PRINCIPAL PROCEDURE CODE / DATE

a. OTHER PROCEDURE CODE / DATE

b. OTHER PROCEDURE CODE / DATE

75

c. OTHER PROCEDURE CODE / DATE

d. OTHER PROCEDURE CODE / DATE

e. OTHER PROCEDURE CODE / DATE

76 ATTENDING NPI 2345678901 QUAL LAST FIRST

77 OPERATING NPI 0123456789 QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS

81 CC a b c d

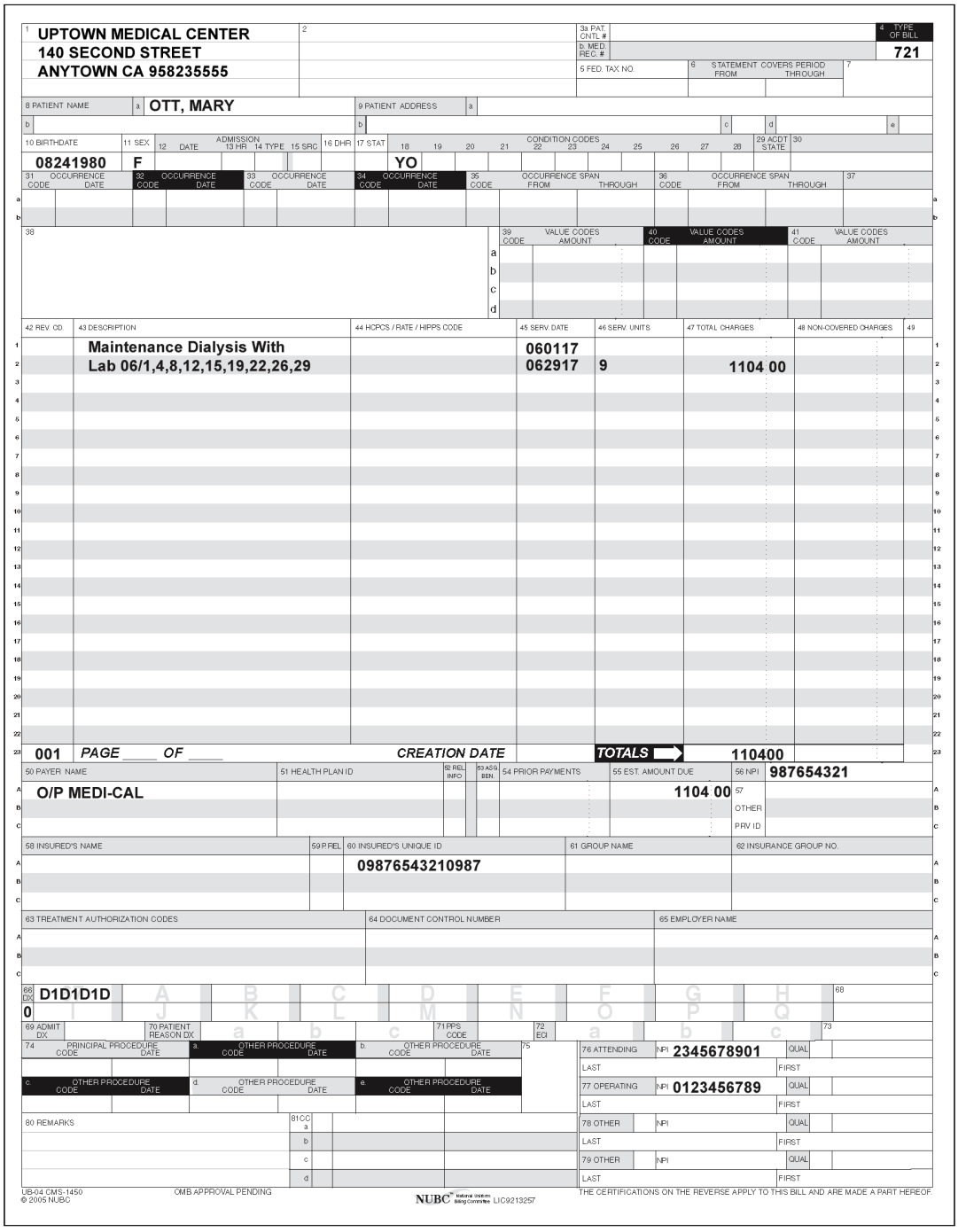
UB-04 CMS-1450 © 2005 NUBC

OMB APPROVAL PENDING

NUBC National Uniform Billing Committee LIC9213257

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

Correct Claim Example



1	UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555
4 TYPE OF BILL	721
8 PATIENT NAME	OTT, MARY
10 BIRTHDATE	08241980
11 SEX	F
17 STAT	YO

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
	Maintenance Dialysis With		060117			
	Lab 06/1,4,8,12,15,19,22,26,29		062917	9	1104 00	
001	PAGE ____ OF ____	CREATION DATE		TOTALS	110400	

50 PAYER NAME	O/P MEDI-CAL
54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE	1104 00
56 NPI	987654321
60 INSURED'S UNIQUE ID	09876543210987
66 DX	D1D1D1D
76 ATTENDING NPI	2345678901
77 OPERATING NPI	0123456789

Resource Information

References

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

Provider Manual References

Part 1

CMC (cmc)

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*)
- *UB-04* Claim Form Tutorial (*https://learn.medi-cal.ca.gov/training.aspx*)
- Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual

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.

Module Objectives

- Review timeliness standards
- Understand *Remittance Advice Details* (RAD)
- Explain claim follow-up options for the *Claims Inquiry Form* (CIF 60-1), the *Appeal* form (90-1) and the Correspondence Specialist Unit (CSU)
- Review CIF (60-1) and Appeal (90-1) form completion
- Introduce the Electronic Claim Resubmission Process

Acronyms

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

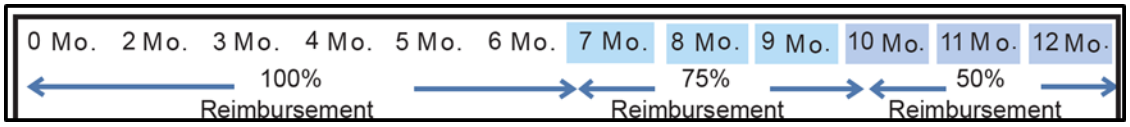
Claim Follow-Up Description

A claim must be received within a specified time frame to process and adjudicate 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 via the RAD.

Claim Reimbursement Guidelines

Claim Submission Timeliness Requirements

Original Medi-Cal or California Children's Services (CCS) claims must be received by the California Medicaid Management Information System (California MMIS) Fiscal Intermediary within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit.



Full Reimbursement Policy

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

Reimbursement Deadlines

If the Date of Service (DOS) falls within this month:	Then claims must be received by 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 California MMIS Fiscal Intermediary without a valid delay reason will be reimbursed at a reduced rate according to the date in which the claim was received.

Partial reimbursement rates are paid as follows:

- 7-9 months after the month of service will be remibursed 75% of the payable amount
- 10-12 months after the month of service will be reimbursed 50% of the payable amount
- Over 12 months with no valid delay reason code will be denied

Claim Follow-Up Process

Medi-Cal claims received by the California MMIS Fiscal Intermediary may not process through the California Medicaid Management Information System (CA-MMIS) as providers anticipate; sometimes claims are denied. Providers can obtain CIFs, Appeal forms and envelopes by contacting the Telephone Service Center (TSC) at 1-800-541-5555.

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

- Minor information is omitted from the claim.
- Information on the claim is incorrect.

CA-MMIS looks at claims critically in a series of edits and audits. After these edits and audits are completed, the claim is adjudicated or suspended.

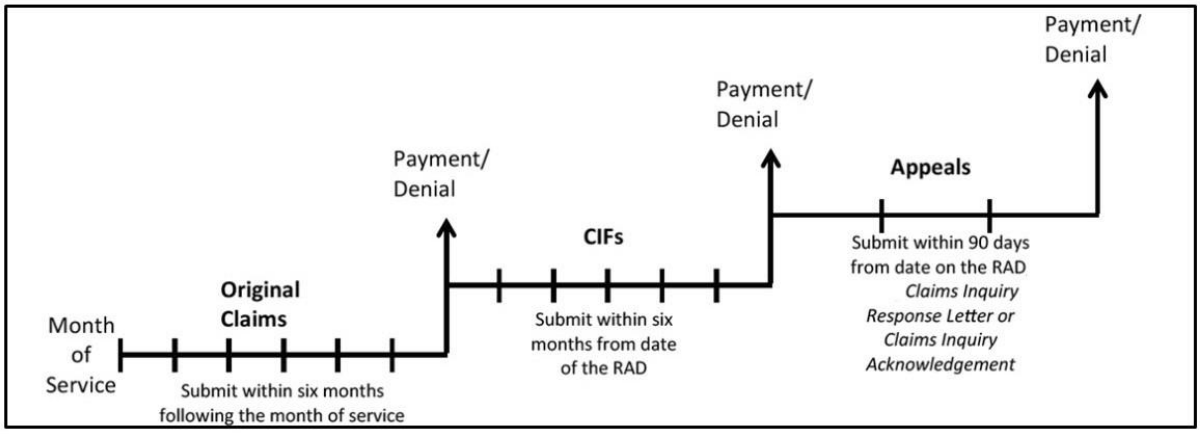
Depending on the reason the claim was denied, the provider can take one of the following follow-up actions:

Table of Provider Follow Up Options when Claim is Denied

If Claim is:	Provider Follow Up Options
Denied	Rebill the claim.
Denied	Submit a *Claims Inquiry Form* (CIF).
Denied	Submit an Appeal form.
Denied	Contact the Correspondence Specialist Unit (CSU).

Timeliness Submission Guidelines

Timeliness submission Guidelines chart.



Remittance Advice Details (RAD) – Financial Reconciliation Statement

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.

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

RAD Access

Providers are able to securely view and download their RAD and a summary sheet called a *Medi-Cal Financial Summary*. The RADs are available on the Medi-Cal Provider Portal website.

Navigating to RADs

1. Navigate to the Medi-Cal Provider Portal. Enter the email address and select **Next**.

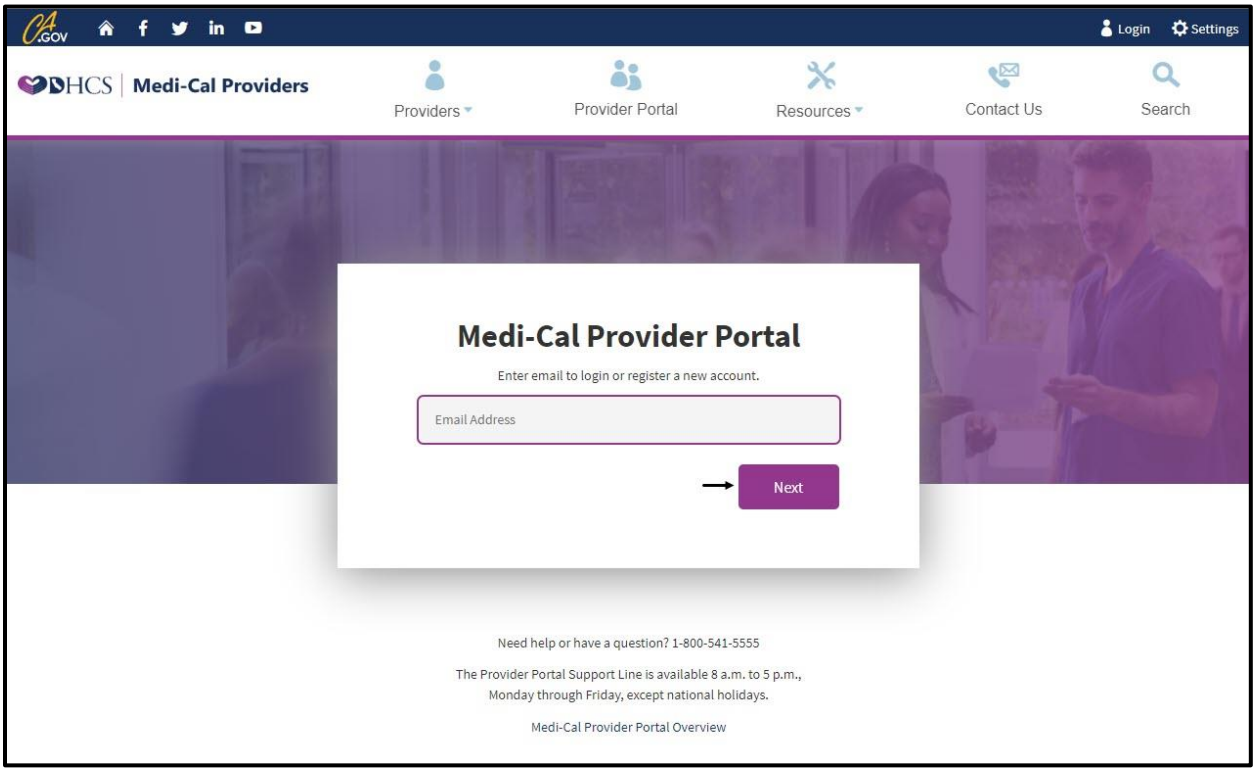


Figure 1.1: The Medi-Cal Provider Portal.

2. On the Login screen, enter the password and select **Log In**.

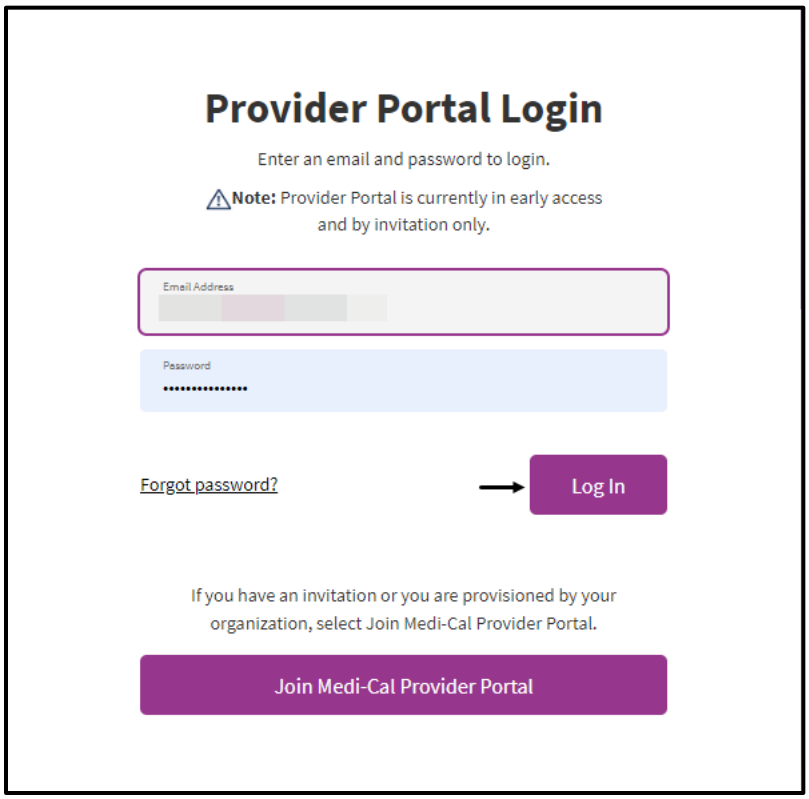


Figure 1.2: Provider Portal login screen.

3. Navigate to the Communication Center and select **Search for Correspondence**.

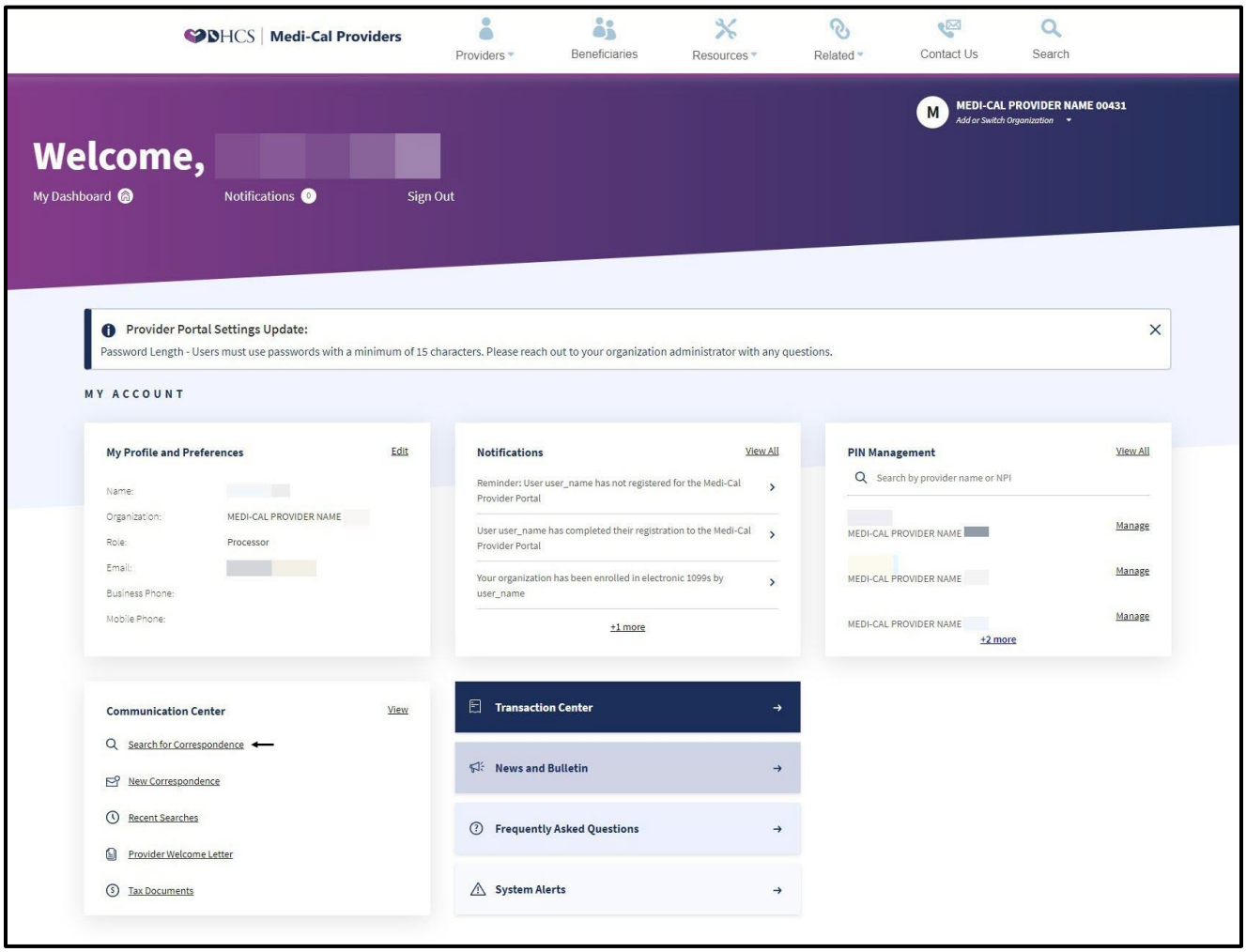


Figure 1.3: Provider Portal homepage.

4. Select the preferred method to receive a one-time passcode and select **Submit.**

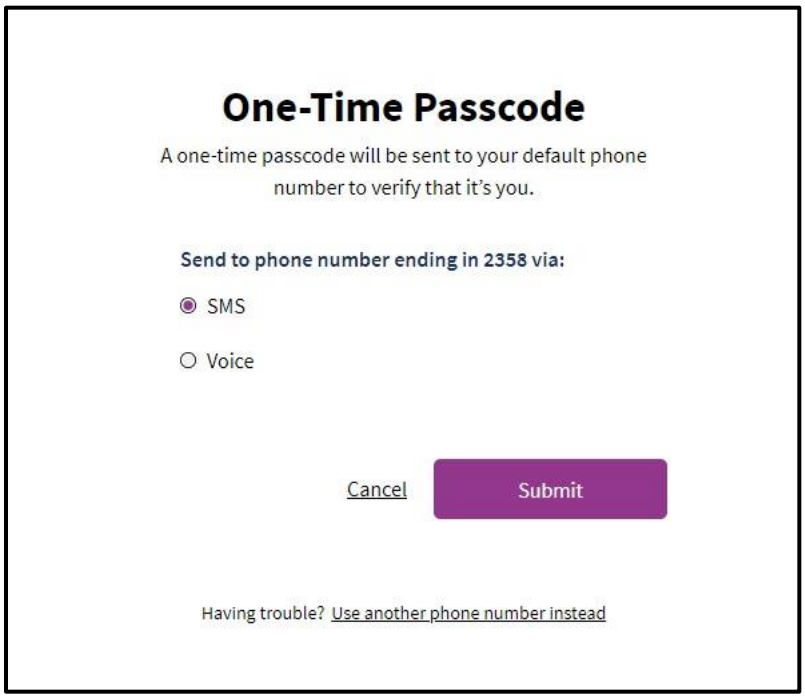


Figure 1.4: One-Time Passcode request.

5. Enter the one-time passcode and select **Next**.

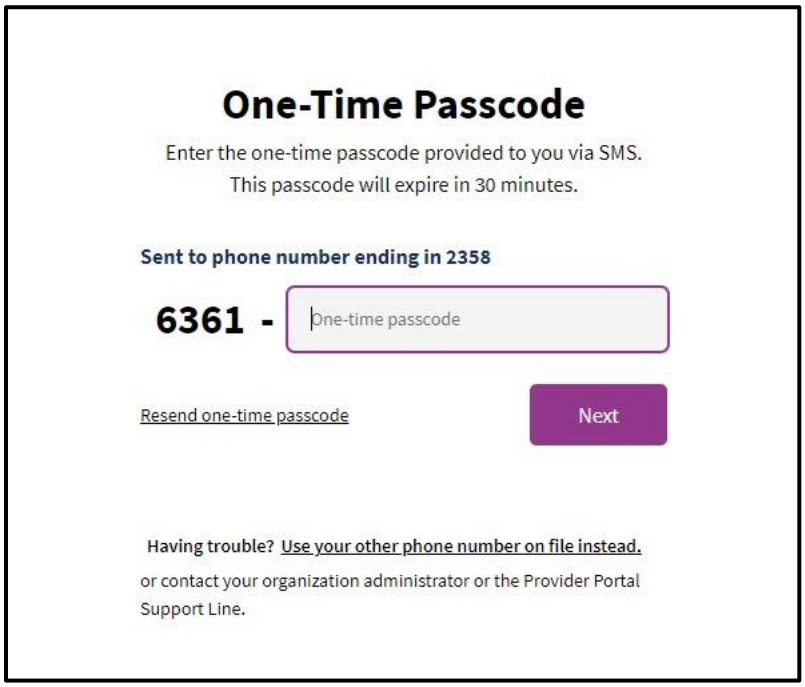


Figure 1.5: One-Time Passcode screen.

6. Select an NPI from the drop-down menu, choose PDF Remittance Advice Detail (RAD) from the Correspondence type drop-down and then enter a date range.

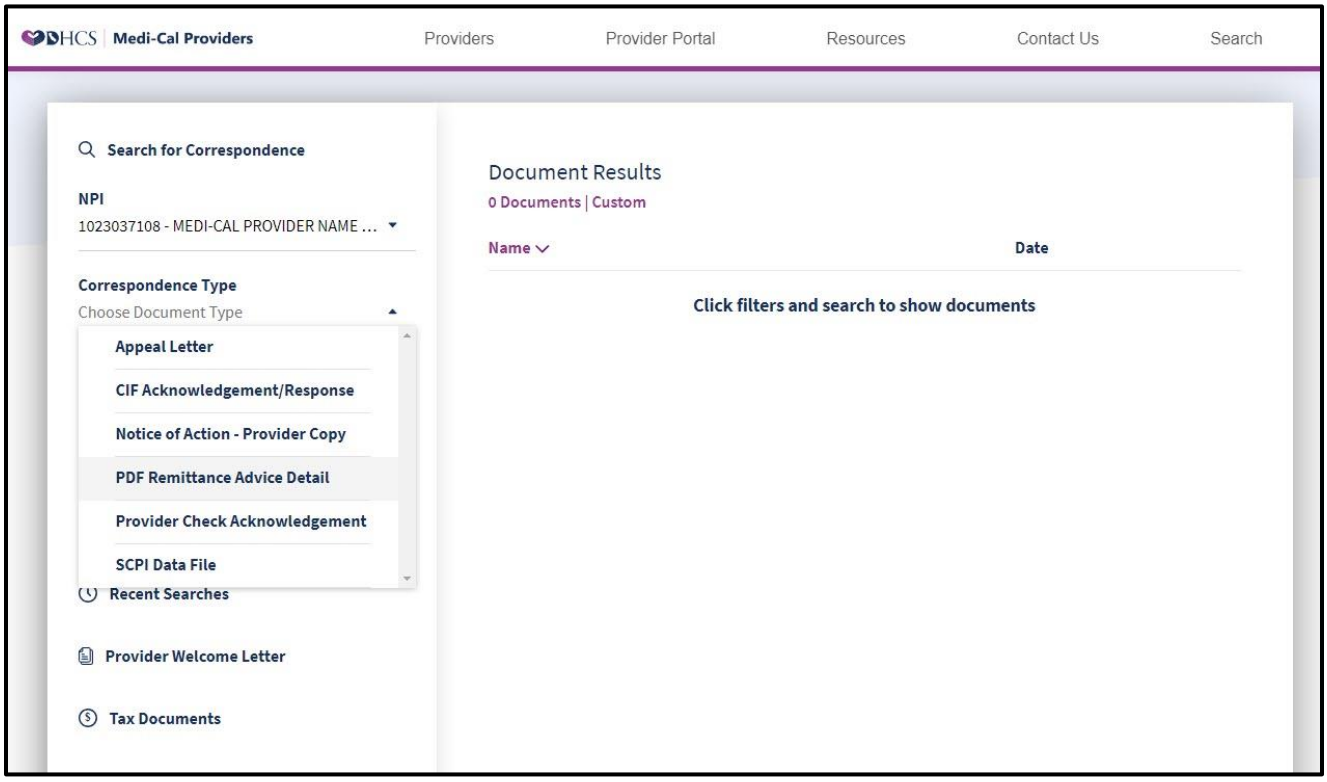


Figure 1.6: Search for Correspondence page.

7. Select the desired RAD, navigate to the vertical ellipse and select the format to download the RAD.

Figure 1.7: Download format options.

PDF RAD Benefits

There are many benefits to accessing RAD and *Medi-Cal Financial Summary* information online:

- The PDF RAD (and embedded financial summary information) is available earlier than paper RADs and financial summaries.
- The PDF RADs and financial summary contains all the information of paper RADs and financial summaries.
- Help California go green by no longer receiving paper RADs.
- Printed versions of the online PDF RADs are adequate to submit as supporting documentation with *Claims Inquiry Forms* (CIFs) and *Appeal* forms.

No provider payments will be made via PDF RADs. PDF RADs are for informational purposes only.

Adjustments

Previously paid claims may be adjusted if an error in payment occurred. An adjustment may be initiated by the provider, the California MMIS Fiscal Intermediary or Department of Health Care Services (DHCS). 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) and reflects the correct payment.
- Line 2 – Shows the original CCN and deducts the original 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. This is a critical step. Sometimes providers void a claim and neglect to submit a new claim, and therefore do not receive payment.

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.

Notes:

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 California MMIS Fiscal Intermediary.

- Billed service is not a program benefit
- Line item fails the edit/audit process

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

Suspensions

Claims requiring manual review will temporarily suspend, but will usually appear as a payment or denial on the RAD within 30 days. Claims still in suspense after 30 days will appear on the RAD with a “suspend” message code. Providers should not submit Claims Inquiry Forms (CIFs) for claims listed as “suspends” on the most recent RAD.

Notes:

Accounts Receivable (A/R) 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 RAD codes appear at the bottom of the page in the RAD message column and begin with the number “7.”

Inquiries about A/R transactions should be mailed to the Financial Cash Control Unit (FCCU). Inquires must be submitted hard copy and include the A/R number and a copy of the RAD.

Attn: Financial Cash Control Unit
California MMIS Fiscal Intermediary
P.O. Box 13029
Sacramento, CA 95813-4029

Notes:

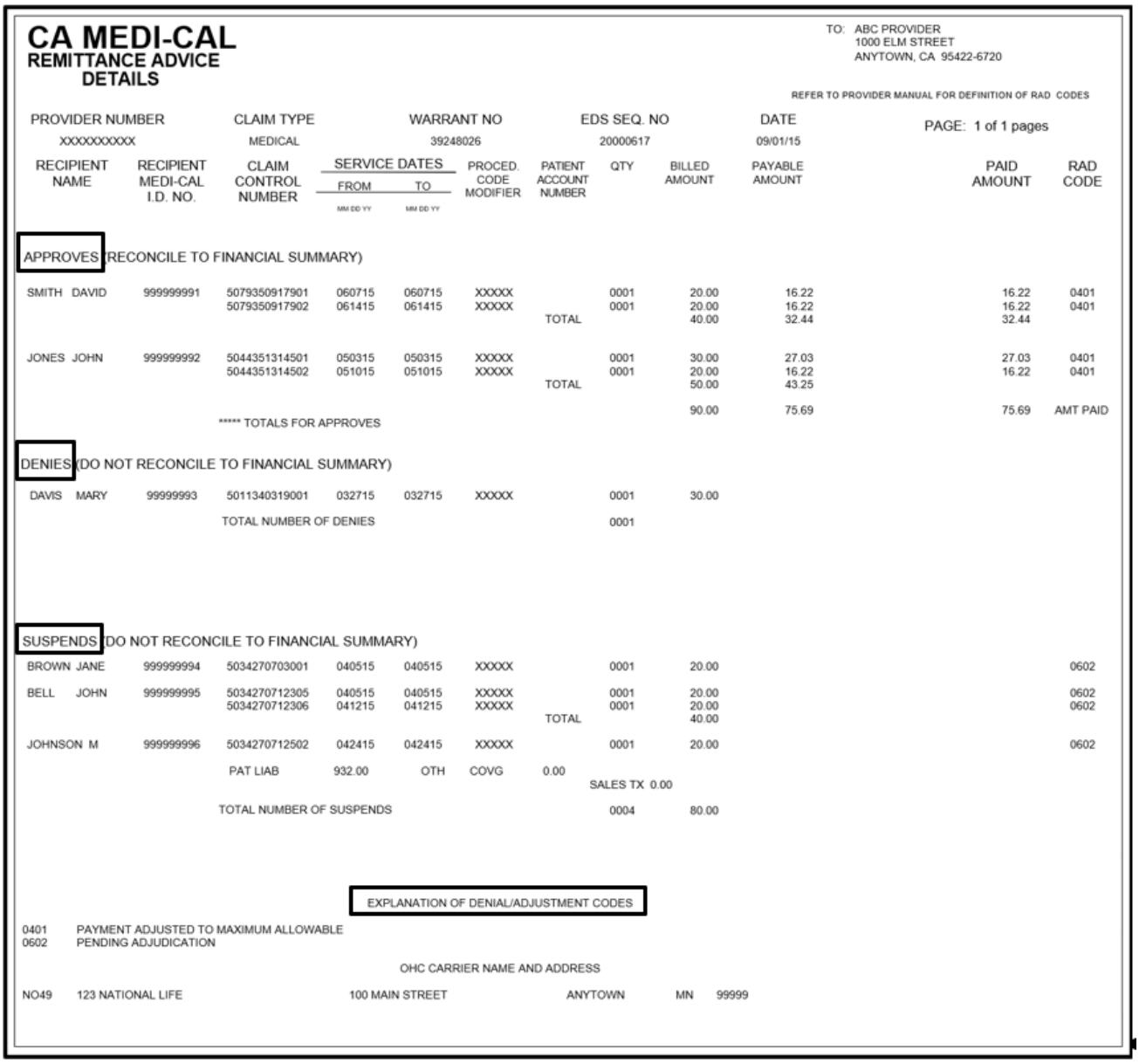
RAD Form Information

- RAD codes appear in the far-right column for each recipient, with a full explanation of the RAD code at the bottom of the RAD
- RADs can include up to a maximum of three denial code messages with some denial codes beginning with a prefix “9” which indicates a free-form error message
- Free-form messages allows the denial message to describe the denial error more accurately
- RAD details will always appear in the same order on a provider’s RAD if applicable in the following order:

- Approves
- Denies
- Suspends
- Explanation of Denials/Adjustment Codes

Remittance Advice Details Form Examples

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



CA MEDI-CAL
REMITTANCE ADVICE DETAILS

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 FROM (MM DD YY)	SERVICE DATES TO (MM DD YY)	PROCED. CODE MODIFIER	PATIENT ACCOUNT NUMBER	QTY	BILLED AMOUNT	PAYABLE AMOUNT	PAID AMOUNT	RAD CODE
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		
		***** TOTALS FOR APPROVES						90.00	75.69	75.69	AMT PAID
DENIES (DO NOT RECONCILE TO FINANCIAL SUMMARY)											
DAVIS MARY	99999993	5011340319001	032715	032715	XXXXX		0001	30.00			
		TOTAL NUMBER OF DENIES					0001				
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
0602 PENDING ADJUDICATION

OHC CARRIER NAME AND ADDRESS

NO49 123 NATIONAL LIFE 100 MAIN STREET ANYTOWN MN 99999

Sample Medi-Cal Financial Summary *Remittance Advice Details* (RAD). Actual size is 8½ x 11 inches.

CALIFORNIA **MEDI-CAL FINANCIAL SUMMARY**

PROVIDER NAME	BANK TRANSIT	ACCOUNT NUMBER	ACS SEQUENCE NUMBER
ABC PROVIDER	1234567	100123456	99999979

PROVIDER NUMBER	PAYMENT DATE	PAYMENT NUMBER	PAYMENT AMOUNT	REMITTANCE
10234567890	01/01/2018	000000000	80000.00	ADVICE PAGES

	ALLOWED (+) AMOUNT	OTHER (-) PAYMENT	ADJUSTMENT INFO (-) DEBIT	ADJUSTMENT INFO (+) CREDIT	AMOUNT PAID
1. PRIOR YTD					
2. PAYMENT SUMMARY:					
3. MEDI-CAL ADJUSTMENTS					
4. MEDI-CAL APPROVES	80000.00				80000.00
5. MEDICARE ADJUSTMENTS					
6. MEDICARE APPROVES					
7. SUB-TOTAL					
8. A/R PAYMENTS					
9. A/R APPLIED (-)					
10. NEGATIVE BALANCE CREATED					
11. WARRANT AMOUNT					
12. CALENDAR YR. TO DATE					
13. NON CASH RECONCILIATION ITEMS:					
14. 1099 ADJUSTMENT (INCREASE)					
15. 1099 ADJUSTMENT (DECREASE)					
16. 1099 ADJUSTMENT FOR PERSONAL CHECK REFUND					
17. CHECKS AND RETURNED WARRANTS					
18. ADJUSTED 1099 AMOUNT					
19. 1099 YTD TOTAL					

State of California
DIRECT DEPOSIT ADVICE

NUMBER

Provider Number	Fund No.	Fund Name
01234567890		

MO	DAY	YR
01	01	18

$ | DOLLARS | CENTS |
|---|---|
| 8000 | 00 |

THIS IS NOT A CHECK

When changing accounts or financial institutions notify the FI immediately. Do not close your old account until you have received your first payment in your new account

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

CA MEDI-CAL

7171

TO:

Remittance Advice Details

REFER TO PROVIDER MANUAL FOR DEFINITION OF RAD CODES

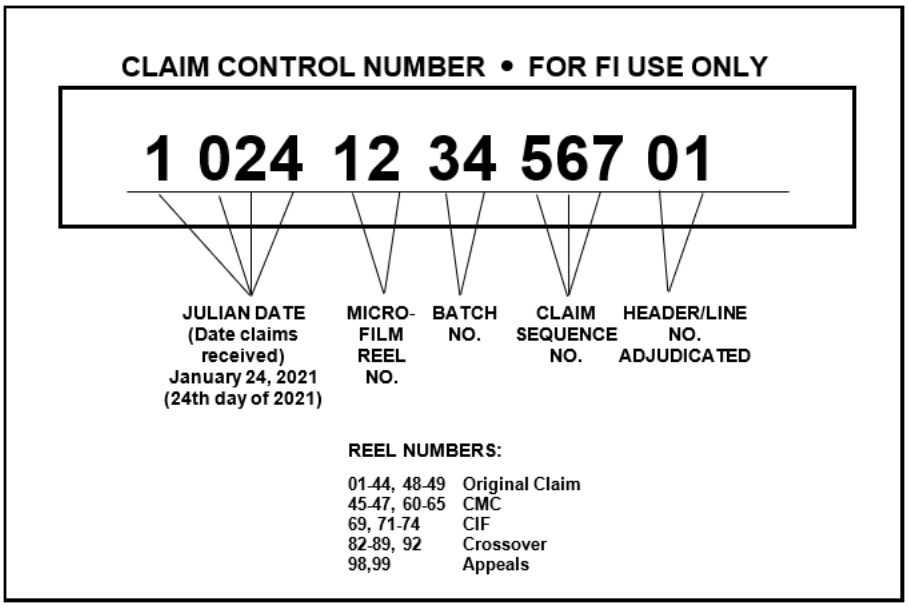
PROVIDER NUMBER	CLAIM TYPE	WARRANT NO.	FI SEQ. NO.	DATE	PAGE:	OF	PAGES
01234567890	,MEDICAL	0000000000	99999979				

RECIPIENT NAME	RECIPIENT MEDI-CAL	CLAIM CONTROL NUMBER	SERVICE DATES FROM MMDDYY	SERVICE DATES TO MMDDYY	PROC. CODE	PATIENT CONTROL NUMBER	QTY	TOTAL CHARGES	NON COVERED	PAYABLE CHARGES	RATE	PAID AMOUNT	RAD CODE
JOHN JONES	0999999991	5079360917901	11/01/18	11/01/18				8000.00	0000	8000.00	1.00	8000.00	

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

Claim Control Numbers

The Claim Control Number (CCN) is used to identify and track Medi-Cal claims as they move through the claims processing system. The CCN contains the Julian date, which indicates the date a claim was received by the California MMIS Fiscal Intermediary, and is used to monitor timely submission of a claim.



Julian Date Calendar

Table of Julian Dates and their Corresponding Claim Control Numbers

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

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 California MMIS Fiscal Intermediary and is used to monitor timely submission of a claim.

For leap years, add one day to the number of days after February 28. Upcoming leap years include 2024 and 2028.

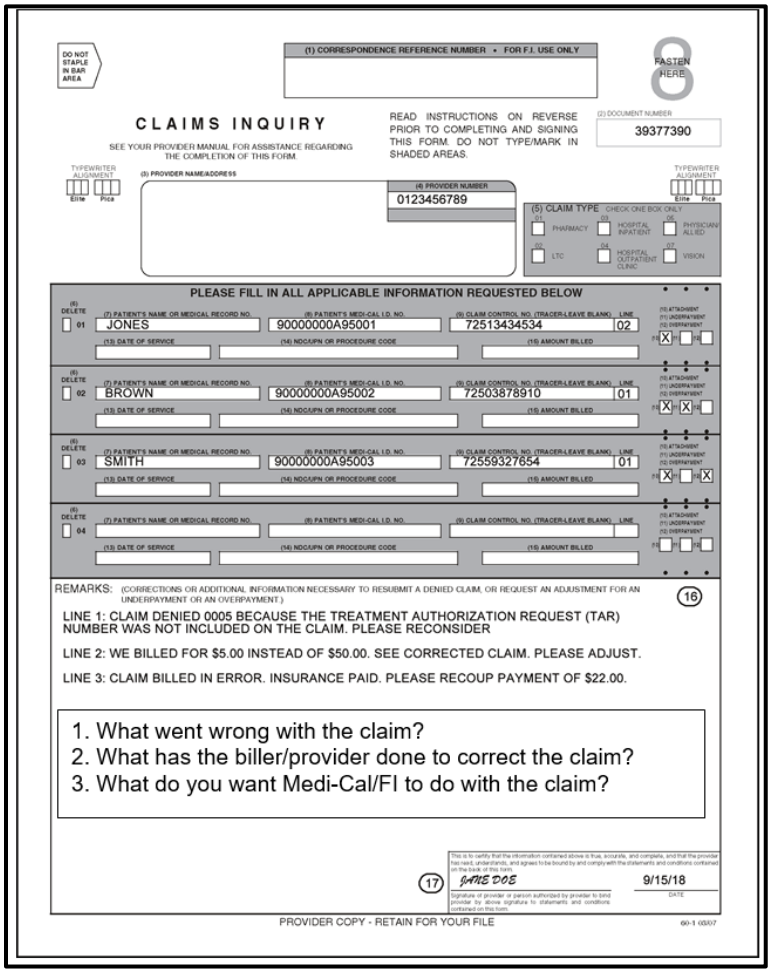
Claims Follow-Up Forms

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 (does not keep claims timely).
- Request reconsideration of a denied claim.
- Adjust an underpayment or overpayment of a claim.
- Request Share of Cost (SOC) reimbursement.

Sample: Claims Inquiry Form (CIF 60-1)



DO NOT STAPLE IN BAR AREA

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

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

(4) PROVIDER NUMBER: 0123456789

(5) CLAIM TYPE CHECK ONE BOX ONLY
01 PHARMACY; 02 LTC; 03 HOSPITAL INPATIENT; 04 HOSPITAL OUTPATIENT CLINIC; 06 PHYSICIAN/ALLIED; 07 VISION

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

(8) DELETE	(7) PATIENT'S NAME OR MEDICAL RECORD NO.	(8) PATIENT'S MEDI-CAL I.D. NO.	(9) CLAIM CONTROL NO. (TRACER-LEAVE BLANK)	LINE	(13) DATE OF SERVICE	(14) NDC/UPN OR PROCEDURE CODE	(15) AMOUNT BILLED	(10) ATTACHMENT (11) UNDERPAYMENT (12) OVERPAYMENT
01	JONES	90000000A95001	72513434534	02				X
02	BROWN	90000000A95002	72503878910	01				X X
03	SMITH	90000000A95003	72559327654	01				X X
04								

REMARKS: (CORRECTIONS OR ADDITIONAL INFORMATION NECESSARY TO RESUBMIT A DENIED CLAIM, OR REQUEST AN ADJUSTMENT FOR AN UNDERPAYMENT OR AN OVERPAYMENT.) (16)

LINE 1: CLAIM DENIED 0005 BECAUSE THE TREATMENT AUTHORIZATION REQUEST (TAR) NUMBER WAS NOT INCLUDED ON THE CLAIM. 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?

(17) JANE DOE — 9/15/18 (DATE)

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

PROVIDER COPY - RETAIN FOR YOUR FILE

60-1 05/07

Explanation of Claims Inquiry Form Items

Box #	Field Title	Description
1	Correspondence Reference Number.	For the FI use only.
2	Document Number.	The pre-imprinted number identifying the CIF.
3	Provider Name/Address	Enter the following information: Provider Name, Street Address, City, State and ZIP code.
4	Provider Number	Enter the provider number.
5	Claim Type	Enter an “X” in the box indicating the claim type. Only one box may be checked.
6	Delete	Enter an “X” to delete the entire line. When box 6 is marked “X,” the information on the line will be “ignored” while the system continues to process the other claim lines. Enter the correct billing information on another line.
7	Patient’s Name or Medical Record Number	Enter up to the first 10 letters of the patient’s last name or the first 10 characters of the patient’s Medical record number.
8	Patient’s Medi-Cal ID Number	Enter the recipient ID number that appears on the Remittance Advice Details (RAD) showing adjudication of that claim.
9	Claim Control Number	Enter the 11-digit Claim Control Number (CCN) in the Claim control No. box, and the two-digit number in the adjoining Line field for the claim line in question. These numbers are assigned by the Fiscal Intermediary (FI) and are found on the RAD. If this item is blank, the inquiry line will be considered a tracer request.
10	Attachment	Enter an “X” when attaching documentation and when resubmitting a denied claim.
11	Underpayment	Enter an “X” for an underpayment
12	Overpayment	Enter an “X” for an overpayment if all or part of the claim was denied.

Explanation of Claims Inquiry Form Items, Continued

Box #	Field Title	Description
13	Date of Service	In six-digit format (MMDDYY), enter the date the service was rendered. For block-billed claims, enter the "From" date of service.
14	NDC/UPN or Procedure Code	Providers should enter the appropriate procedure code, modifier, drug or supply code if applicable. Codes of fewer than 11 digits should be left-justified. For outpatient claims, do not enter the revenue code in this field. Long Term Care and Inpatient providers leave blank.
15	Amount Billed	Enter the amount originally billed, using the right box to represent cents.
16	Remarks	Use this area to state the reason for submitting a CIF and include the corresponding line number if listing multiple claim lines on the CIF.
17	Signature	The provider or an authorized representative must sign the CIF.

Note: All claims inquiries should have attachments except when submitting a tracer. Refer to the *CIF Submission and Timeliness Instructions* (cif sub) section of the Part 2 provider manual.

CIF Completion Tips

Note: Providers can obtain CIFs, Appeal forms and envelopes free of charge by contacting the Telephone Service Center (TSC) at 1-800-541-5555

Chart of Acceptable CIF Attachments

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.	Yes	No	No	No	No	No
Enter no more than four claim inquiries per form. **Note:** This does not apply to crossover and inpatient claims.	Yes	No	No	No	No	No
Fill out each line completely. Do not use ditto marks (“) or draw an arrow to indicate repetitive information.	Yes	No	No	No	No	No
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.	Yes	No	No	No	No	No
Only one claim line per CIF.	No	No	Yes	No	No	No
Be sure the recipient ID number and Claim Control Number on the CIF exactly match the numbers on the RAD.	Yes	No	No	No	No	No
RAD not required.	No	No	No	No	Yes	Yes

Chart of Acceptable CIF Attachments (continued)

CIF Completion Reminders	All Inquiries	Adjustments	Crossover, Inpatient and Pharmacy Compounds	Denial	SOC	Tracer
Enter the recipient's original ID (the number issued prior to being enrolled in a no-SOC program).	No	Yes	No	No	Yes	No
Do not use the *Remarks* area for additional inquiries.	Yes	No	No	No	No	No
State clearly and precisely what is being requested in the *Remarks* area.	Yes	No	No	No	No	No
Always indicate the denial or adjustment reason code in the *Remarks* area.	No	Yes	No	Yes	No	No
Secure documentation to the upper right-hand corner of the CIF.	No	Yes	Yes	Yes	Yes	No
Do not attach any documentation.	No	No	No	No	No	Yes
Only original CIFs are accepted. Photocopies will be returned.	Yes	No	No	No	No	No

.

CIF Adjustments – Underpayment/Overpayment and Voids

A CIF adjustment should be used to correct both under and over payments. However, this transaction type is different than requesting a full payment recovery, which is a void.

CIF Adjustments – One-Step Process

If requesting an adjustment for an underpaid or overpaid claim, the adjustment is completed in one transaction, with the adjudication results appearing on a future RAD. The corrected CCN will appear as a credit and debit and be reflected on the same RAD.

CIFs submitted for underpayments must be received within six months from the date of the RAD. CIFs received after six months on which the underpayment was indicated are subject to an automatic denial.

CIF Voids

A CIF void can be requested to fully recover or recoup monies paid. In many instances, the provider's goal is to return funds. The CIF void process accomplishes this in one-step. However, if the provider wishes to void the original payment and submit a corrected claim, this cannot be done. The CIF void is largely an automated process and cannot perform two functions; therefore, only the void can be processed.

CIF Adjustments – Two-Step Process

Providers requiring a void and subsequent resubmission of a corrected claim, must use a two-step process. The CIF void must first be submitted to recoup the full payment. Once the void appears on a future RAD, the provider completes the second step by submitting an *Appeal* to request the processing of the corrected claim. If a provider submits a corrected claim before the void appears on the RAD, the claim may deny as a duplicate, since the original claim has not yet completed the void process.

Note: The *Appeal* must be filed within 90 days from the date indicated on the RAD on which the void appeared and must include a copy of the corrected claim, a copy of the RAD that indicated the payment retraction and any other supporting documentation.

Reconsideration

To request reconsideration of a denied claim line after the six-month billing limit, attach a legible copy of the corrected original claim form, a copy of the RAD dated within six months of the denial date and all pertinent documentation.

Trace

Provider has 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.

Where to submit CIFs

CIFs should be submitted in black and white envelopes available from the California MMIS Fiscal Intermediary to the following address:

California MMIS Fiscal Intermediary
P.O. Box 15300
Sacramento, CA 95851-1300

Claims Inquiry Form Attachments

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

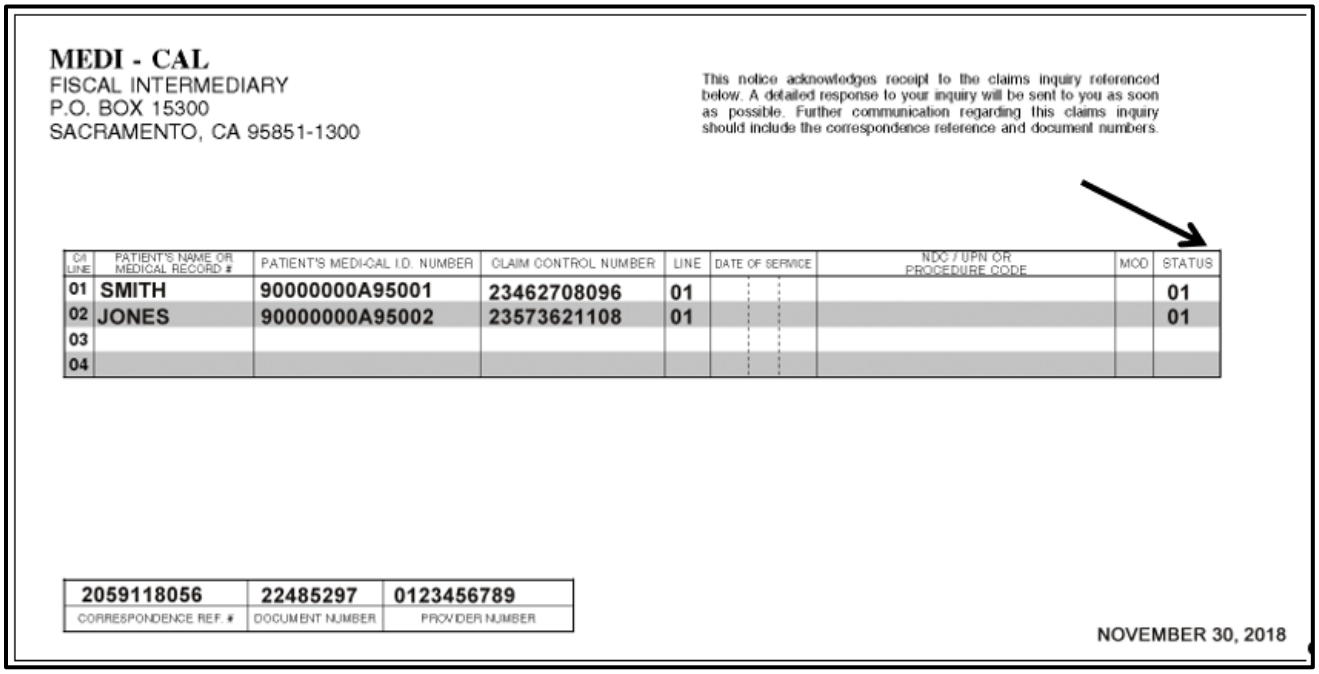
- TAR indicating authorization
- "By Report" documentation
- Completed *Sterilization Consent Form* (PM 330)
- *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN)/*National Standard Intermediary Remittance Advice* (Medicare RA)
- *Explanation of Benefits* (EOB) from Other Health 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
- Internet eligibility response attached to the claim on an 8 ½ x 11-inch sheet of white paper

Note: All supporting documentation must be legible.

Claims Inquiry Acknowledgement

Within 15 days of receipt, the California MMIS Fiscal Intermediary 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 California MMIS Fiscal Intermediary does not respond after the initial CIF is filed, providers should file an appeal.

Sample: *Claims Inquiry Acknowledgement*



MEDI - CAL
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.

CII LINE	PATIENT'S NAME OR MEDICAL RECORD #	PATIENT'S MEDI-CAL I.D. NUMBER	CLAIM CONTROL NUMBER	LINE	DATE OF SERVICE	NDC / UPN OR PROCEDURE CODE	MOD	STATUS
01	SMITH	90000000A95001	23462708096	01				01
02	JONES	90000000A95002	23573621108	01				01
03								
04								

2059118056	22485297	0123456789
CORRESPONDENCE REF. #	DOCUMENT NUMBER	PROVIDER NUMBER

NOVEMBER 30, 2018

Table: Status Numbers and Corresponding Messages for Claims Inquiry Acknowledgement

Status Numbers	Messages
01	Accepted for resubmission of denied claim or underpayment/overpayment.
02	Accepted. Tracer status letter will be generated.
03 thru 05	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.

Exceptions to Using CIFs

- Incorrect provider number was used
- All claims denied for National Correct Coding Initiative (NCCI)
- Denied inpatient claims if claim lines must be added or deleted
- Suspended claims appearing on a current *Remittance Advice Details* (RAD) form
- RAD Code denials: 0002, 0010, 0072, 0095, 0326, 0525, 9941 and 9942 (Appeals should be submitted)

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). An *Appeal* form only allows a single recipient; therefore, a form must be completed for each individual.

Sample Appeal Form 90-1 Example

DO NOT STAPLE IN BAR AREA

(1) APPEAL REFERENCE NUMBER
F.I. USE ONLY

FASTEN HERE 2

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

APPEAL

(2) DOCUMENT NUMBER GXXXXXXX

TYPEWRITER ALIGNMENT ELITE PICA

TYPEWRITER ALIGNMENT ELITE PICA

(3) PROVIDER NAME/ADDRESS

ABC PROVIDER
1234 MAIN STREET
ANYTOWN CA 958235555

(4) PROVIDER NO. 0123456789

(5) CLAIM TYPE
CHECK ONE BOX ONLY

- 01 [ ] PHARMACY
- 02 [ ] LTC
- 03 [ ] HOSPITAL INPATIENT
- 04 [ ] HOSPITAL OUTPATIENT/ CLINIC
- 05 [X] PHYSICIAN/ ALLIED
- 07 [ ] VISION

(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 MEDI-CAL FISCAL INTERMEDIARY.

PLEASE FILL IN ALL APPLICABLE INFORMATION REQUESTED BELOW

(7) PATIENT'S NAME OR MEDICAL RECORD NO.: SMITH

(8) PATIENT'S MEDI-CAL I.D. NO./SSN: 90000000A95001

(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.

(9) DELETE		(10) CLAIM CONTROL NO.	DATE (11) OF SERVICE	EOB/RA (12) CODE
[ ]	01	1234567890123		
[ ]	02	1234567890124		
[ ]	03	1234567890125		
[ ]	04			
[ ]	05			
[ ]	06			
[ ]	07			
[ ]	08			
[ ]	09			
[ ]	10			
[ ]	11			
[ ]	12			
[ ]	13			
[ ]	14			

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

- [ ] ELIGIBILITY (POE ATTACHED)
- [ ] TAR DENIAL (TAR ATTACHED)
- [ ] CROSSOVER (EOMB ATTACHED)
- [ ] 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*
SIGNATURE OF PROVIDER OR PERSON AUTHORIZED BY PROVIDER TO BIND PROVIDER BY ABOVE SIGNATURE TO STATEMENTS AND CONDITIONS CONTAINED ON THIS FORM.

030118
DATE

FORM# 90-1 (3/07)

Explanation of Appeal Form Items

Box #	Field Title	Description
1	Appeal Reference Number	For FI use only.
2	Document Number	The pre-imprinted number identifying the *Appeal Form*. This number can be used when requesting information about the status of an appeal.
3	Provider Name/Address	Enter the following information: Provider Name, Street Address, City, State, and ZIP code.
4	Provider Number *(required field)*	Enter the provider number. Without the correct provider number, appeal acknowledgement may be delayed.
5	Claim Type (*required field*)	Enter an “X” in the box indicating the claim type. Only one box may be checked.
6	Statement of Appeal	For information purposes only.
7	Patient’s Name or Medical Record Number	Enter up to the first 10 letters of the patient’s last name or the first 10 characters of the patient’s medical record number.
8	Patient’s Medi-Cal ID Number/SSN *(required field)*	Enter the recipient ID number that appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card.
9	Delete	If an error is made, enter an “X” in this box to delete If an error is made, enter an “X” in this box to delete information on the line will be “ignored” by the system and will information on the line will be “ignored” by the system and will not be processed as an appeal line. Enter the correct billing information on another line.
10	Claim Control Number *(required field if appealing a previously adjudicated claim).*	Enter the 13-digit number assigned by the FI to the claim line in question. (This number is found on the *Remittance Advice Details* [RAD]). This field is not required when appealing a non-adjudicated claim (for example, a “traced” claim that could not be located).

Explanation of Appeal Form Items, Continued

Box #	Field Title	Description
11	Date of Service	In six-digit format (MMDDYY) enter the date the service was rendered. For claims billed in a “from- through” format, you must enter the “from” date of service.
12	RAD Code or EOB/RA Code	When appealing, enter the RAD code being appealed, (for example, 010, 072, 401).
13	Reason for Appeal	Indicate the reason for filing an appeal. Be as specific as possible. Include all supporting documentation to help examiners properly research the complaint.
14	Common Appeal Reason	Check one of these boxes if applicable. Include a copy of the claim and supporting documentation (for example, TAR, EOMB). This box is for convenience only. Leave Box 13 blank if this box is used.
15	Signature	The provider or an authorized representative must sign the *Appeal Form.*

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

Attn: Appeals Unit
California MMIS Fiscal Intermediary
P.O. Box 15300
Sacramento, CA 95851-1300

All supporting documentation must be legible. The following attachments as they apply to the claim are 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 California MMIS Fiscal Intermediary documenting timely follow-up
- Reports 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)

The California MMIS Fiscal Intermediary 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.

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.

Table of Appeal Form 90-1 Fields and Instructions

Field Numbers	Completion Instructions
3, 4, 5, 7, 8, 10, 11 and 12	These fields are required for all appeal types.
4, 5, 8 and 10	*Provider Number, Claim Type, Patient's Medi-Cal ID Number* and *Claim Control Number* are completed to process an appeal. If these fields are left blank, providers may receive an appeal rejection letter requesting resubmission of a corrected *Appeal* 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

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.

Electronic Claim Resubmission to avoid Paper CIFs/Appeals

Providers can electronically resolve a claim denial or incorrect payment for 837I (Institutional) and 837P (Professional) electronic claims.

By submitting the claim with either frequency type code “7” (replacement of prior claim) or “8” (void/cancel of prior claim), there is no longer a need to adjust the claim using a paper *Claims Inquiry Form* (CIF) or *Appeal* forms with accompanying *Remittance Advice Details* (RADs) to show proof of previous claim payment or denial. Electronic claim resubmission is not available for pharmacy claims.

The ANSI X12 v.5010 837 electronic transactions claim format allows a provider to initiate changes to already-adjudicated claims. The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called “claim frequency codes.”

Replacement and void claims can be sent in the same batch as new claims. Electronic replacement claims must be submitted within six months of the previous claim payment or denial. Providers may submit an electronic follow-up claim even if the original was a paper claim. Claims for which a CIF or appeal are already in progress must not be electronically resubmitted. Claims for which a CIF or appeal is in progress will be denied.

The following chart outlines the use of codes “7” and “8”.

Table of Frequency Type Codes 7 and 8

Claim Frequency Code/Definition	Use	Filing Guidelines	Result
7 Replacement of Prior Claim	Use to replace a claim line or entire claim in an already adjudicated paid or denied claim (see following instructions per claim type)	File the claim line or entire electronic claim including all services for which reconsideration is requested	Medi-Cal will adjust the original claim. The corrections submitted will be reflected on the 835 Transaction and/or paper *Remittance Advice Details* (RAD) and other standard claim responses
8 Void/Cancel of Prior Claim	Use to eliminate an already adjudicated claim for a specific provider, recipient and date of service (see following instructions per claim type)	File the claim electronically and include all claims data and charges that were on the original claim	Medi-Cal will void the original claim from history based on request, which will be reflected on the 835 Transaction and/or paper RAD and other standard claim responses

Frequency Type Code ‘7’

Electronic **allied health, long term care, medical services, obstetric, outpatient and vision care** claims resubmitted with Frequency Type code “7” (replacement claim):

- Are used to modify only one claim line. They cannot be used to replace multiple original claim lines.
- Must include a separate replacement claim transaction for each claim line being replaced. For example, to replace all five lines of an outpatient claim, the submitter must submit five separate transactions.
- Must contain corrected information for the original claim.
- Must include the 13-digit Claim Control Number (CCN) from the original paid claim. For the claim to be considered for full reimbursement, the RAD date for the previous claim payment or denial must be within six months of the date the replacement claim was submitted.

Electronic **inpatient** claims resubmitted with Frequency Type code “7” (replacement claim):

- Replace the entire inpatient care claim.

Frequency Type Code ‘8’

Electronic **long-term care, medical services, outpatient and vision care** claims resubmitted with Frequency Type code “8” (void/cancel claim):

- Must include the 13-digit CCN from the original paid claim.
- Serve as a full void for one claim line only. Multiple original claim lines cannot be voided with one void claim transaction.
- Must include a separate void claim transaction for each claim line being voided. For example, to void all five lines of an outpatient claim, the submitter must submit five separate transactions.

Electronic **inpatient** claims resubmitted with Frequency Type code “8” (void/cancel claim):

- Void the entire inpatient care claim.

Errors to Avoid

Providers should pay attention to the instructions above that certain claim types can replace or void one claim line only. Additionally, the CCN of the original claim is the proper information to insert in the REF segment.

Correct CCN for Crossover Claims

Providers resubmitting a Medicare to Medi-Cal crossover claim should take care to enter the CCN from the Medi-Cal claim they are resubmitting and not the CCN from the Medicare claim.

Claim Attachments

Attachments required with the initial claim submission are required for replacement claim submissions. Copies of claims initially submitted on paper are not needed. Information from the paper claim will already have been keyed into the claims processing system.

No attachments are required when voiding a claim.

Information about submitting attachments for electronic claims is available in the *Billing Instructions: Acceptable Claims, Attachments and ASC X12N 835 v.5010 Transactions* section of the *Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual*, specifically under the following headings:

- “Supporting Documentation – Attachments”
- “Attachment Control Form: Required and Optional Fields”
- “Attachment Control Form (ACF) Guidelines”

Associated RAD Code and Correlation Table Update

The following Remittance Advice Details (RAD) message has been added in the *RAD Repository* to help providers reconcile claims submitted using claim frequency code “7” (The claim frequency code is the third digit of the “Type of Bill” Code.)

9174 RAD Code Table

Code	Message
9174	Computer Media Claims (CMC) replacement submitted after six months of referred claim *Remittance Advice Details* (RAD) is not payable

Reimbursement

If the initial adjudicated claim was subject to a reimbursement reduction due to late claim submission, then reimbursement for the resubmitted claim also will be reduced.

Correspondence Specialist Unit (CSU)

The Correspondence Specialist Unit (CSU) resolves complex billing issues. TSC agents may refer you to the CSU for inquiries that require additional research.

Providers may write directly to CSU for clarification about recurring billing issues that have not been resolved through either the *Claims Inquiry Form* (CIF) or Appeal process and have resulted in claim denials. Correspondence Specialists respond to providers in writing to clarify billing procedures.

When writing to CSU for assistance, providers should enclose up to three examples of Claim Control Numbers (CCNs) to help establish the history in order to resolve the billing issues. Include as much of the following documentation as possible with the letter of inquiry:

- Legible with claim form.
- Proof of eligibility.
- Necessary documentation, operative report, invoice, etc.
- Copies of Remittance Advice Details (RAD).
- Copies of all CIF acknowledgements, response letters.
- Copies of all Appeal acknowledgements, response letters.
- Copies of all dates correspondence from the previous/current California MMIS Fiscal Intermediary.

A lack of necessary records may delay research.

Letters to CSU should be addressed to the California MMIS Fiscal Intermediary in a plain white envelope as follows:

Attn: Correspondence Specialist Unit
California MMIS Fiscal Intermediary
P.O. Box 13029
Sacramento, CA 95813-4029

New Provider Financial Data Request Form

Providers are now able to utilize the Provider Financial Data Request Form (4520), when requesting financial data from the Financial Cash Control Unit (FCCU). Using this form will enable Providers to save time determining what is needed for questions regarding missing warrants, copies of RADs, accounts receivable transactions and copies of 1099's.

Providers reaching out to the FCCU for assistance with any of these services must complete the Provider Financial Data Request Form. Please note that each form may only contain a single request and must be filled out in its entirety including provider number, reason for request and signature to avoid delays due to missing information.

Mail the completed form to the following address:

California MMIS Fiscal Intermediary
Attn: Financial Cash Control Unit
P.O. Box 13029
Sacramento, CA 95813-4029

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 documenting timely follow-up *(must be on California MMIS Fiscal Intermediary letterhead)*
- ☐ Reports 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)*

Resource Information

References

The following reference materials provide Medi-Cal claim information.

Provider Manual References

Part 1

Claim Submission and Timeliness Overview (claim sub)
Remittance Advice Details (RAD) and Financial Summary; Click link: Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations

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)
UB-04 Completion: Outpatient Services (ub comp ob)
UB-04 Submission and Timeliness (ub sub)

Resource Tools

Medi-Cal Providers website

Telephone Service Center (TSC):

1-800-541-5555

Provider Field Representatives:

Call the TSC and ask for a Provider Field Representative to visit your office

Appendix

Acronyms

Acronym	Description
ACF	Attachment Control Form
ACN	Attachment Control Number
AEVS	Automated Eligibility Verification System
AR	Adjudication Response
BIC	Benefits Identification Card
CA-MMIS	California Medicaid Management Information System
CCN	Claim Control Number
CCS	California Children's Services
CHDP	Child Health and Disability Prevention
CIF	Claims Inquiry Form
CIN	Client Index Number
CMC	Computer Media Claims
CMS	Centers for Medicare & Medicaid Services
CMSP	County Medical Services Program
COBC	Coordination of Benefits Contractor
CPSP	Comprehensive Perinatal Services Program
CPT-4	Current Procedural Terminology 4th Edition
CSU	Correspondence Specialist Unit
DHCS	Department of Health Care Services
DME	Durable Medical Equipment
DOB	Date of Birth
DOI	Date of Issue

Acronyms

Acronym	Description
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
ERA	Electronic Remittance Advice
EVC	Eligibility Verification Confirmation
FI	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
GHPP	Genetically Handicapped Persons Program
HAP	Health Access Program
HCFA	Health Care Financing Administration
HCP	Health Care Plan
HCPCS	Healthcare Common Procedure Coding System
HIC	Health Insurance Claim
HIPAA	Health Insurance Portability and Accountability Act
ICD-10-CM	International Classification of Disease, 10th Revision, Clinical Modification
ICF	Intermediate Care Facility
KDE	Key Data Entry
LTC	Long Term Care
LMP	Last Menstrual Period
LOA	Letters of Authorization
MCP	Medi-Cal Managed Care Plans
NCCI	National Correct Coding Initiative
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NF	Nursing Facility
NMP	Non-Physician Medical Practitioner
NPI	National Provider Identifier
NUCC	National Uniform Claim Committee

Acronyms

Acronym	Description
OCR	Optical Character Recognition
OHC	Other Health Coverage
PI	Pricing Indicator
POE	Proof of Eligibility
POS	Point of Service
RAD	Remittance Advice Details
RR	Responsible Relative
RTD	Resubmission Turnaround Document
RTIE	Real Time Internet Eligibility
SAR	Service Authorization Request
SOC	Share of Cost
SNF	Skilled Nursing Facility
TAR	Treatment Authorization Request
TCN	TAR Control Number
TSC	Telephone Service Center
UB	Universal Billing

Module A Learning Activity: Answer Key

Knowledge Review 1

Question 1: When a recipient provides their BIC card, this means they are Medi-Cal Eligible?

Answer 1: False

Question 2: What can be identified when using the BIC card to determine eligibility?

Answer 2: f. All of the Above.

Question 3: A provider may ask for a second form of ID to help confirm a recipient's identification.

Answer 3: True

Knowledge Review 2

Question 1: To access recipient eligibility, providers must have the following information?

Answer 1: ID Number, Date of Birth, Date of Issue.

Module B Learning Activity: Answer Key

Knowledge Review 1

Question 1: What is the recipient's SOC for the month of service?

Answer 1: $50

Question 2: What is the recipient's remaining SOC as of the date of service?

Answer 2: $50

Knowledge Review 2

Question 1: Generally, a recipient's SOC is determined by the county Department of Social Services (or welfare) 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.

Answer: 1: True

Question 2: Claims submitted for services rendered to a recipient whose SOC is not certified through the Medi-Cal eligibility verification system will be denied.

Answer 2: True

Question 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.
Answer 3: False

Question 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.

Answer 4: True

Question 5: Once a recipient has been certified as having met the SOC, reversal transactions can no longer be performed.

Answer 5: True

Knowledge Review 3

Question 1: When will a provider collect or obligate the SOC for each month in which services were provided?

Answer 1: Per-visit basis

Question 2: The same medical expenses may be used to clear SOC for both CMSP and Medi-Cal.

Answer 2: True

Question 3: Clearing SOC for one program does not automatically clear SOC for the other program.

Answer 3: True

Question 4: When the recipient is eligible for both Medicare and Medi-Cal, providers should collect the Medi-Cal SOC at the time of service.

Answer 4: False

Knowledge Review 4

Question 1: The first case number listed on an eligibility response will correspond with the recipient for whom eligibility is being verified.

Answer 1: False

Question 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?

Answer 2: Yes

Question 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?

Knowledge Review 5

Question 1: What information will be submitted on this claim form? How will the collected SOC be entered on the claim form?

Answer 1: Refer to the *Share of Cost (SOC): CMS-1500* section (share cms) in the appropriate Part 2 provider manual.

Knowledge Review 6

Question 1: What information will be submitted on this claim form? How will the collected SOC be entered on the claim form?

Answer 1: The provider submits a bill to Medi-Cal. Cost of the services rendered totals $125 in Box 28. The first service is not billed.to Medi-Cal because the entire charge is paid as a SOC by the recipient. The provider billed Medi-Cal for the $50 service because this is a provider's usual and customary amount. The SOC covered only $10 of that charge. Refer to the *Share of Cost (SOC): CMS-1500* section (share cms) in the appropriate Part 2 provider manual.

Knowledge Review 7

Question 1: What information will be submitted on this claim form? How will the collected SOC be entered on the claim form?

Answer 1: Refer to the *Share of Cost (SOC): UB-04 Inpatient Services* section (share ip) in the appropriate Part 2 provider manual.

Knowledge Review 8

Question 1: What information will be submitted on this claim form based on the case scenario from the previous page? How will the collected SOC be entered on the claim form?

Answer 1: Refer to the *Share of Cost (SOC): UB-04 Outpatient Services* section (share op) in the appropriate Part 2 provider manual.

Module C Learning Activity: Answer Key

Knowledge Review 1

Question 1:List two requirements for a retroactive TAR.

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

Knowledge Review 2

Question 1: What is the 11-digit TCN that will be used when submitting a claim for service #1?

Answer 1: 98765432101

Module D Learning Activity: Answer Key

Box #	Incorrect Data Entries	Correct Data Entries
1	Medicare (checked)	The Medicaid box should be marked.
1A	90000000000A	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 not use dollar signs or decimals.
21	ICD Ind. (blank)	0
24D	2	Enter the appropriate procedure code (CPT or HCPCS) and modifier(s). Enter modifiers in the boxes provided. The descriptor for the code must match the procedure performed, and the modifier(s) must be billed appropriately.
24F	$62500	Do not 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)	Service facility name and address without a comma between the city and state is required with a nine-digit ZIP code without a hyphen.
32A	(blank)	Enter the 10-digit NPI number of the facility.
33	(ZIP code missing)	The nine-digit ZIP code of the billing provider is required without a hyphen.

Module E Learning Activity: Answer Key

Box #	Incorrect Data Entries	Correct Data 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 (Line 2)	9	Field should be blank.
46 (Line 2)	(blank)	Nine. The number of items must equal the number of “from-through” dates listed. The claim indicates nine in the incorrect field (Box 44, Line 2).
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.
56	(blank)	Billing provider’s NPI 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.

Page updated: September 2020

Enter Notes Here