LTC (UB-04) Claim Completion

Introduction

Purpose

The purpose of this module is to provide participants with detailed information about the completion of the Long-Term Care (LTC) *UB-04* claim form requirements for the Medi-Cal program. 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. Most claims for LTC services can also be submitted through Computer Media Claims (CMC).

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

For additional billing information, refer to the following sections in Part 2 provider manual:

- UB-04 Completion: LTC Services Billing examples
- UB-04 Submission and Timeliness Instructions
- LTC crosswalk guides and FAQ link
- UB-04 Tips for Billing LTC Services

Module Objectives

- Review LTC UB-04 claim form
- Provide field-by-field general completion instructions
- Introduce LTC crosswalk guides and FAQ link
- Discuss the claims follow-up options

Acronyms

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

LTC Facility UB-04 Claim Completion

Effective for dates of service on or after February 1, 2024, the fee-for-service LTC local service codes and the local *Payment Request for Long Term Care* (25-1) claim form will be replaced with HIPPA-compliant national code sets and the UB-04 claim form.

With the fee-for service LTC code and claim form conversion, LTC providers can expect to prepare and submit claims according to the instructions below.

LTC Facility Types include the following:

- Hospital – Swing Beds
- Skilled Nursing – Inpatient (including Medicare Part A)
- Skilled Nursing - Inpatient (Medicare Part B only)
- Skilled Nursing – Outpatient
- Skilled Nursing – Swing Beds
- Intermediate Care – Level I
- Intermediate Care – Level II

For more information on UB-04 Form Completion Guidelines, refer to UB-04 Claim Form located on the Medi-Cal Providers website.

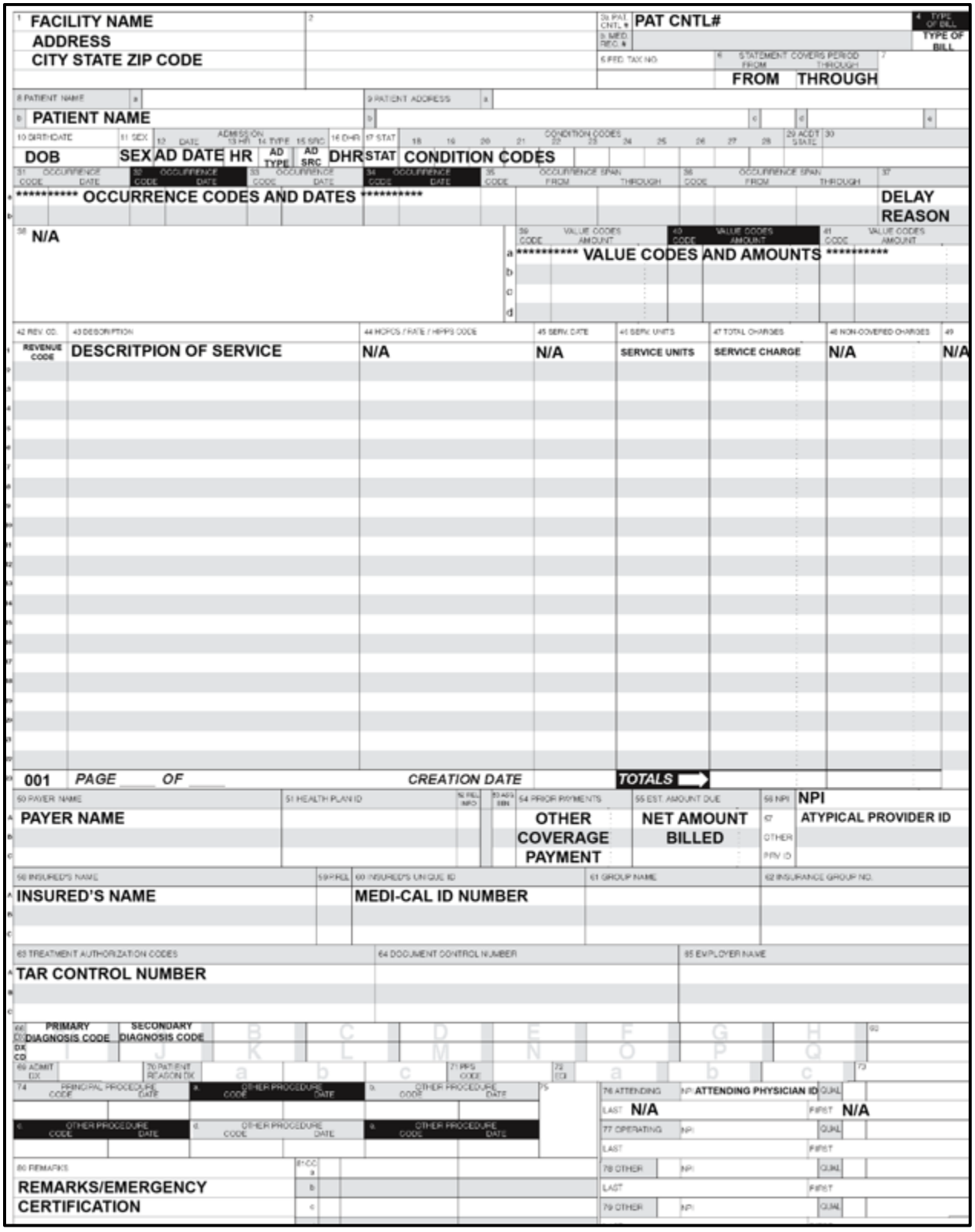


Figure 1.1: Sample *UB-04* Claim Form

Explanation of Form Items

The following item numbers and descriptions correspond to the sample *UB-04* claim form on the previous page for completing LTC Medi-Cal claims and LTC Medi-Cal Part A coinsurance and Part B crossover claims. All items must be completed unless otherwise noted. Only one month's services can be billed on each claim form.

All instructions are applicable to both paper and CMC claims except where noted.

For general paper claim and CMC billing instructions, review the *Forms: Legibility and Completion Standards* and CMC sections in Part 1 of the provider manual.

For additional crossover billing information, refer to the LTC Code and Claim Conversion: Forthcoming Crossover Changes section of the LTC Claim Form and Code Conversion web page.

Required Claim Form Items

Note: Items described as "Note required by Medi-Cal" may be completed by other payers but are not recognized by the Medi-Cal claims processing system.

Claim Form Items

Figure 1.2: Partial *UB-04* Claim Form

Table of Form Items Descriptions

Item	Description
1.	**Unlabeled** (Use for facility information). Enter the facility name. Enter the address, without a comma between the city and state, and a 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.
2.	**Unlabeled**. For FI Use only. This field must be left blank on all claims submitted to Medi-Cal.
3a.	**Patient Control Number**. This is an optional field that will help you to easily identify a recipient on *Remittance Advices* (RAs). Enter the patient's financial record number or account number in this field. A maximum of 20 numbers and/or letters may be used, but only 10 characters will appear on the RA. Refer to the *Remittance Advice Details (RAD) Examples: Long Term Care* manual section for Patient Control Number information.
3b.	**Medical Record Number**. Not required by Medi-Cal. Use Box 3a to enter a patient control number. This number will not appear on the RAD for recipient clarification. The Patient Control Number (Item 3) will appear on the RAD.
4.	**Type of bill.** Enter the appropriate three-character type of bill code as specified in the *National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual.* This is a required field when billing Medi-Cal. The following facility type codes are a subset of the *National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual f*acility type codes commonly used by Medi-Cal. Use one of the following codes in the table below as the first two digits of the three-character type of bill code.

LTC Facility Type Code Descriptions (Item 4)

Code	Facility Type
18	Hospital – Swing Beds
21	Skilled Nursing – Inpatient (including Medicare Part A)
22	Skilled Nursing – Inpatient (Medicare Part B only)
23	Skilled Nursing – Outpatient
28	Skilled Nursing – Swing Beds
65	Intermediate Care – Level I
66	Intermediate Care – Level II

Table of Form Items Descriptions (continued)

Item	Description
5.	**Federal tax number.** Not required by Medi-Cal.
6.	**Statement covers period (from – through).** In six-digit MMDDYY (Month, Day, Year) format, enter the dates of service included in this billing. Bill only to one calendar month of service at a time. Be sure the authorization dates on the TAR cover the period billed. For example, April 5, 2023, is written 040523. **Note**: When a patient is discharged, the thru date of service must be the discharge date. When a patient expires, the thru date of service must be the date of death.

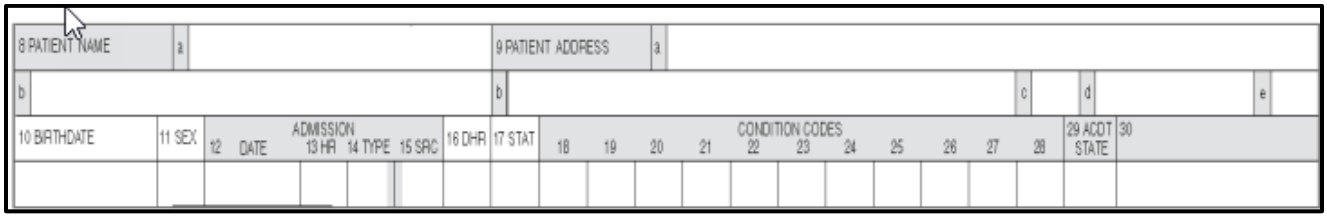


Figure 1.3: Partial *UB-04* Claim Form

Table of Form Items Descriptions (continued)

Item	Description
7.	**Unlabeled.** Not required by Medi-Cal.
8a.	**Patient name – ID**. Not required by Medi-Cal.
8b.	**Patient name**. Enter the patient's last name, first name and middle initial (if known). Avoid nicknames or aliases.
9a thru e.	**Patient address.** Not required by Medi-Cal.
10.	**Birthdate**. Enter the patient's date of birth in an eight-digit MMDDYYYY (Month, Day, Year) format (for example, September 16, 1967 = 09161967). If the recipient's full date of birth is not available, enter the year preceded by 0101.
11.	**Sex**. Use the capital letter "M" for male, or "F" for female.
12 thru 13.	**Admission date and hour**. In a six-digit format, enter the date of hospital admission. Enter the admit hour as follows: • Eliminate the minutes • Convert the hour of admission/discharge to 24-hour (00 to 23) format (for example, 3 p.m. = 15) **Note**: Although providers can enter this date, the claims processing system shall utilize the Admit Date from the Treatment Authorization Request (TAR).

Table of Form Items Descriptions (continued)

Item	Description
14.	**Admission type**. Enter the numeric code indicating the necessity for admission to the hospital: • Emergency – 1 • Urgent – 2 • Elective – 3 • Newborn – 4 • Information not available – 9 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).
15.	**Admission source**. If the patient was transferred from another facility, enter the numeric code indicating the source of transfer. When completing this field, code "1" or "3" must be entered in Box 14 to indicate whether the transfer was an emergency or elective. A baby born outside the hospital: In cases where the type of admission code in Box 14 is "4" (newborn [used by Medi-Cal only when a baby is born outside the hospital]), submit the claim with source of admission code "4" (extramural birth) in Box 15 and the appropriate revenue code in Box 42.

Table of Admission Code Source Descriptions (Item 15)

Admission Code Source	Description
4	Transfer from a hospital
5	Transfer from a Skilled Nursing Facility
6	Transfer from another health care facility

Table of Form Items Descriptions (continued)

Item	Description
16.	**Discharge hour**. Enter the discharge hour as follows: • Eliminate the minutes • Convert the hour of discharge to 24-hour (00 to 23) format (for example, 3 p.m. = 15) If the patient has not been discharged, leave this box blank.
17.	**Status.** Enter one of the following numeric codes from the table below to explain patient status as of the "Through" date indicated in (Box 6) under "Statement Covers Period." The patient status code must agree with the Revenue Code and Value Code/Amount combination (that is, if the status code indicates leave days, the Revenue Code and Value Code/Amount combination must also indicate leave days). Refer to the LTC Patient Status Code to Patient Discharge Status Code Crosswalk for information/mapping between local and national/NUBC status codes. Refer to the Leave of Absence, Bed Hold, and Room and Board provider manual for detailed leave days billing instructions. **Note**: FI does not require a copy of Form MC-171 (*Notification of Patient Admissions, Discharge, or Death*) to be attached to the UB-04 claim form.

Patient Status Code Descriptions (Item 17)

Code	Explanation
01	Discharged to home or self-care (routine discharge)
02	Discharged/transferred to a short-term general hospital for inpatient care
03	Discharged/transferred to a Skilled Nursing Facility (SNF) with Medicare certification in anticipation of covered skilled care
04	Discharged/transferred to a Facility that Provided Custodial or Supportive Care
05	Discharged/transferred to a Designated Cancer Center or Children's Hospital
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07	Left against medical advice or discontinued care
09	Admitted as inpatient to this hospital
20	Expired
21	Discharged/transferred to court/law enforcement
30	Still a patient
40	Expired at home
41	Expired in a medical facility
42	Expired – place unknown
43	Discharged/transferred to a federal health care facility
50	Hospice – home
51	Hospice – medical facility (certified) providing hospice level of care
61	Discharged/transferred to hospital-based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility (IRF), including rehabilitation distinct part units of a hospital
63	Discharged/transferred to a Medicare certified Long Term Care hospital (LTCH)
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a Critical Access Hospital (CAH)
69	Discharged/transferred to a Designated Disaster Alternate Care Site
70	Discharged/transferred to another Type of Health Care Institution not defined elsewhere in this code list

Table of Form Items Descriptions (continued)

Item	Description
18 thru 24.	**Condition codes**. Condition codes are used to identify conditions relating to this claim that may affect payer processing. Although the Medi-Cal claims processing system only recognizes the condition codes on the following pages, providers may include codes accepted by other payers. The claims processing system ignores all codes not applicable to Medi-Cal. Condition 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”, “80” and “82”, enter “80” in Box 18, “82” in Box 19 and “A1” in Box 20. Applicable Medi-Cal codes are: Other Coverage: Enter code “80” if recipient has Other Health Coverage (OHC). OHC includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient’s health care needs. Eligibility under Medicare or a Medi-Cal managed care plan is not considered OHC and is identified separately. Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient’s other health insurance coverage prior to billing Medi-Cal. For details about OHC, refer to the *Other Health Coverage (OHC) Guidelines for Billing* section in the Part 1 manual. Emergency Certification: Enter code “81” when billing for emergency services. An Emergency Certification Statement must be attached to the claim or entered in the *Remarks* field (Box 80). The statement must be signed by the attending provider. It is required for any service rendered under emergency conditions. These statements must be signed and dated by the provider and must be supported by a physician’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 the *Remarks* field (Box 80), attach the statement to the claim. Medicare Status: Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional; therefore, providers may leave this area of the *Condition Codes* fields (Boxes 18 thru 24) blank on the *UB-04* claim. The Medicare status codes are:

Medicare Status Code Descriptions (Items 18 thru 24)

Code	Description
Y0	Under 65, does not have Medicare coverage
Y1 *	Benefits exhausted
Y2 *	Utilization committee denial or physician non-certification
Y3 *	No prior hospital stay
Y4 *	Facility denial
Y5 *	Non-eligible provider
Y6 *	Non-eligible recipient
Y7 *	Medicare benefits denied or cut short by Medicare intermediary
Y8	Non-covered services
Y9 *	PSRO denial
Z1 *	Medi/Medi Charpentier: Benefit Limitations
Z2 *	Medi/Medi Charpentier: Rates Limitations
Z3 *	Medi/Medi Charpentier: Both Rates and Benefit Limitations

Note: The asterisk (*) indicates documentation is required.

Table of Form Items Descriptions (continued)

Item	Description
25 thru 28.	**Condition Codes**. The Medi-Cal claims processing system only recognizes condition codes entered in Boxes 18 thru 24.
29.	**ACDT state**. Not required by Medi-Cal.
30.	**Unlabeled**. Not required by Medi-Cal.

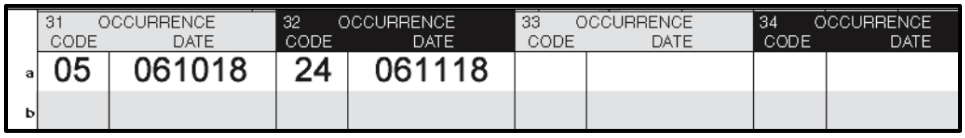


Figure 1.4: Occurrence Codes

Table of Form Items Descriptions (continued)

Item	Description
31 thru 34a thru b.	**Occurrence Codes and Dates**. Occurrence codes and dates are used to identify significant events relating 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 sequence starting with the lowest value. For 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. Although the Medi-Cal claims processing system will only recognize applicable Medi-Cal codes, providers may 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. Applicable Medi-Cal codes are: Enter “04” (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related. Enter on of the following codes from the table below if the accident or injury was non-employment related. Discharge Date. In six-digit MMDDYY (Month, Day, Year) format, enter code “42” and the date of facility discharge when the date of discharge is different than the “Through” date in Box 6.

Occurrence Code Descriptions (Items 31 thru 34a thru b)

Code	Description
01	Accident/medical coverage
02	No fault insurance involved – including auto accident/other
03	Accident/tort liability
05	Accident/no medical or liability coverage
06	Crime victim

Table of Form Items Descriptions (continued)

Item	Description
35 thru 36a thru b.	**Occurrence Span Codes and Dates**. Occurrence Span codes and dates are used to identify events that relate to the payment of the claim. Occurrence Span codes and dates should be entered from left to right, top to bottom in numeric-alpha sequence starting with the lowest value. For example, if billing for two Occurrence Span codes “70” (Qualifying Stay For SNF) and “MR” (Disaster Related), enter “70” in Box 35a and “MR” in Box 36a. Although the Medi-Cal claims processing system will only recognize applicable Medi-Cal codes, providers may include codes and dates billed to other payers in Boxes 35 thru 36. The claims processing system will ignore all codes not applicable to Medi-Cal. In addition, this field is required if the claim is for a Leave if Absence. Refer to the Leave of Absence, Bed Hold, and Room and Board Provider Manual for detailed leave days billing instructions. Applicable Medi-Cal codes are: Enter code “74” (Non-Covered Level of Care/Leave of Absence Dates) if the claim is for a Leave of Absence of any type. Enter code “M4” (Residential Level of Care) if the claim is for Leave of Absence to the patient’s home and the patient has not been discharged. In six-digit MMDDYY (Month, Day, Year) format, enter the dates of service associated with the Occurrence Span codes. Refer to the LTC Patient Status Code to Patient Discharge Status Code Crosswalk for information/mapping between local and national/NUBC patient status codes.

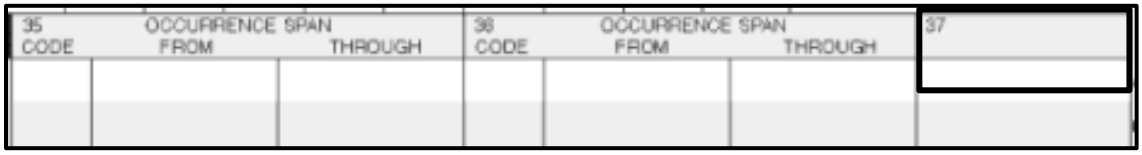


Figure 1.5: Partial *UB-04* Claim Form.

Table of Form Items Descriptions (continued)

Item	Description
37a.	**Unlabeled (Use for delay reason codes)**. Enter one of the following delay reason codes in the following table, and include the required documentation, if there is an exception to the six-month from the month of service billing limit. Refer to the UB-04 Submission and Timeliness Instructions manual section for detailed information about codes and documentation requirements.

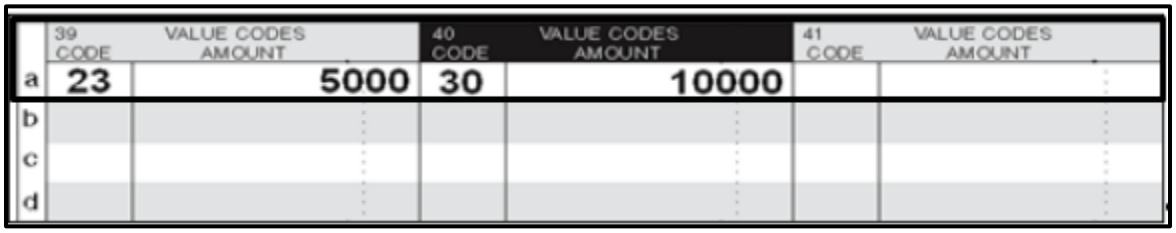
Delay Reason Code Description and Documentation (Item 37a)

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 delay	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

Note: The Yen symbol "¥" indicates documentation justifying the delay reason must be attached to the claim to receive full payment. Providers billing with delay reason "11" without an attachment will either receive reimbursement at a reduced rate or a claim denial. Refer to "Reimbursement Reduced for Late Claims" in the UB-04 Submission and Timeliness Instructions section of this manual.

Table of Form Items Descriptions (continued)

Item	Description
37b.	**Unlabeled**. Not required by Medi-Cal.
38.	**Unlabeled**. Not required by Medi-Cal.



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

Figure 1.6: Partial *UB-04* Claim Form.

Table of Form Items Descriptions (continued)

Item	Description
39 thru 41a thru b.	**Value Codes and Amount**. Patient's Share of Cost. Value codes and amounts are used to relate amounts to data elements necessary to process the claim. Value codes and amounts should be entered from left to right, top to bottom in numeric-alpha sequence, starting with the lowest value. For example, if billing for two value codes "24" (Medicaid Rate Code) and "23" (Accepted By Medi-Cal), enter "23" in Box 39a and "24" in Box 40a. Although the Medi-Cal claims processing system only recognizes select codes, providers may include codes and amounts billed to other payers in Boxes 39 thru 41. The claims processing system will ignore all codes not applicable to Medi-Cal. 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, refer to the Share of Cost (SOC): UB-04 for Long Term Care manual section. Enter "23" and the amount of the patient's Share of Cost for the service, if applicable. The recipient's net SOC liability is the amount billed to the recipient. The recipient's net SOC liability is determined by subtracting from the recipient's original SOC (listed on the Medi-Cal eligibility verification system) the amount expended by the recipient that qualifies under Medi-Cal rules to reduce the patient's SOC liability. For continuing recipients, such qualifying expenditures will generally be those for necessary medical or remedial services or items "not covered" by Medi-Cal. The SOC amount entered in this box must agree with the "TOTAL SOC DEDUCTED FROM LTC CLAIM" entered on the DHCS 6114 form, Item 15. When billing the recipient for less than the SOC amount indicated by the Medi-Cal eligibility verification system, show why in the *Remarks* field (Box 80). The SOC amount is deducted from the amount billed to Medi-Cal. Enter "24" (Medicaid Rate Code) and the corresponding Designated State Level Medicaid Rate Code on the Value code and amount fields associated with LTC services. The Designated State Level Medicaid Rate Code should be entered in the "cents" portion of the Value Code Amount Field. Refer to the *LTC Accommodation Code to Revenue Code, Value Code and Value Code Amount Crosswalk* for information/mapping between local and national/NUBC billing codes.

Table of Form Items Descriptions (continued)

Item	Description
42	**Revenue Code**. Enter the appropriate revenue code. Total Charges: Enter "001" on line 23, and enter the total amount on line 23, field 47. Refer to the *LTC Accommodation Code to Revenue Code, Value Code and Value Code Amount Crosswalk* for information/mapping between local and national/NUBC billing codes.
43	**Description**. Enter the description of the Revenue Code used in Box 42. **Note**: If there are multiple pages of the claim, enter the page numbers on line 23 in this field.
44	**HCPCS/rate/HIPPS code**. Not required by Medi-Cal.
45	**Service Date**. Not required by Medi-Cal.
46	**Service Units (Accommodation Days)**. Enter the number of days of care by Revenue Code.
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 amount is even (for example, if billing for $100, enter 10000 not 100). When billing for full Medi-Cal coverage, compute the 'Total Charges' by multiplying the number of days times the appropriate Medi-Cal daily rate for the Revenue Code and Designated State Level Medicaid Rate Code listed. **Note**: Medi-Cal cannot process credits or adjustments on the UB-04 claim form. Refer to the CIF Completion and CIF Special Billing Instructions for Long Term Care manual sections for information regarding claim adjustments. Enter the "Total Charge" for all services on Line 23. Enter code 001 in *Revenue Code* field (Box 42) to indicate that this is the total charge line (refer to Item 42 on a preceding page).
48	**Non-covered charges**. Not required by Medi-Cal
49	**Unlabeled**. Not required by Medi-Cal. **Note**: Providers may enter up to 22 lines of detail data (Items 42 thru 49), but only if they are associated with the other claim information entered (for example Statement Coverers Period, Status, etc.). It is also acceptable to skip lines. To delete a line, mark through the boxes. Be sure to draw a thin line through the entire detail line using a blue or black ballpoint pen.

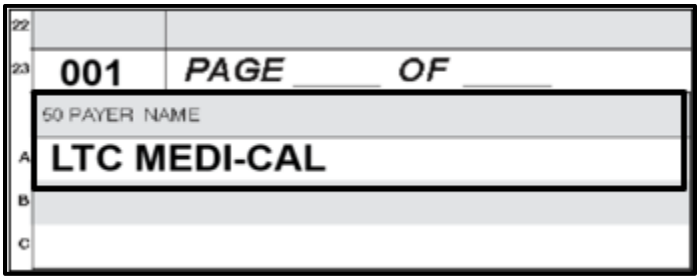


Figure 1.7: *UB-04* Payer Name

Table of Form Items Descriptions (continued)

Item	Description
50a thru c	**Payer name**. Enter “LTC MEDI-CAL” to indicate type of claim and payer. Use capital letters only. 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. **Reminder**: If the recipient has Other Health Coverage (OHC), the insurance carrier must be billed prior to billing Medi-Cal.
51a thru c	**Health plan ID**. Not required by Medi-Cal

Table of Form Items Descriptions (continued)

Item	Description
52a thru c	**Release of Information Certification Indicator**. Not required by Medi-Cal.
53a thru c	**Assignment of Benefits Certification Indicator**. Not required by Medi-Cal.
54a thru b	**Prior Payment (Other Coverage).** Enter the full dollar amount of payment received from Other Health Coverage on the same line as the Other Health Coverage "payer" (Box 50). Do not enter a decimal point (.), dollar sign ($), positive (+) or negative (-) sign. Leave blank if not applicable. Other Health Coverage (OHC) includes insurance carriers as well as Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) that provide any of the recipient's health care needs. **Note**: If the Medi-Cal eligibility verification system indicates a scope of coverage code "L" for the recipient, providers must bill other insurance carriers prior to billing Medi-Cal. For more information about OHC, refer to the Other Health Coverage (OHC) manual section.
55a thru c	**Estimated amount due (net amount billed)**. In full dollar amount, enter the difference between "Total Charges" and any deductions (for example, patient's Share of Cost and/or Other Coverage). Do not enter a decimal point (.) or dollar sign ($).

Table of Estimated Amounts

Dollar Amount	Location on Form
Total Charges	(Box 47) Revenue code 001
Deductions (Minus) -	Share of Cost (Box 39, 40 or 41a thru d/ Value code 23) and Other Coverage (Box 54a or b)
Net Billed (Equals) =	(Boxes 55a thru c)

Table of Form Items Descriptions (continued)

Item	Description
56	**NPI**. Enter the National Provider Identifier (NPI). Be sure to include all ten characters of the number. Do not submit claims using a Medicare provider number or State license number. Claims from providers and/or billing services that bill with anything other than an NPI will be denied. Note to CMC Users: Anytime a provider number is changed, a new provider application/agreement form must be submitted to the CMC unit to allow continued CMC billing using the new provider number. For more information, refer to the *CMC Enrollment Procedures* section in the Part 1 manual.
57a thru c	**Other (billing) provider ID (used by atypical providers only)**. Not required by Medi-Cal. **Note**: Required prior to the mandated NPI implementation date when an additional identification number is necessary to identify the provider, or if on and after the mandated NPI implementation, 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.
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 here and the patient's relationship to the Medi-Cal recipient in Box 59 (*Patient's Relationship to Insured*). See Item 8a on a previous page in this section. This box is not required by Medi-Cal except under the two circumstances listed here.
59a thru c	**Patient's Relationship to Insured. 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]). See Item 8b on a previous page in this section. This box is not required by Medi-Cal except under the two circumstances listed here.
60a thru c	**Insured's Unique ID**. Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC) or paper Medi-Cal ID card. **Note**: Medi-Cal does not accept Medicare ID numbers.
61a thru c	**Group Name**. Not required by Medi-Cal.
62a thru c	**Insurance Group Number**. Not required by Medi-Cal.

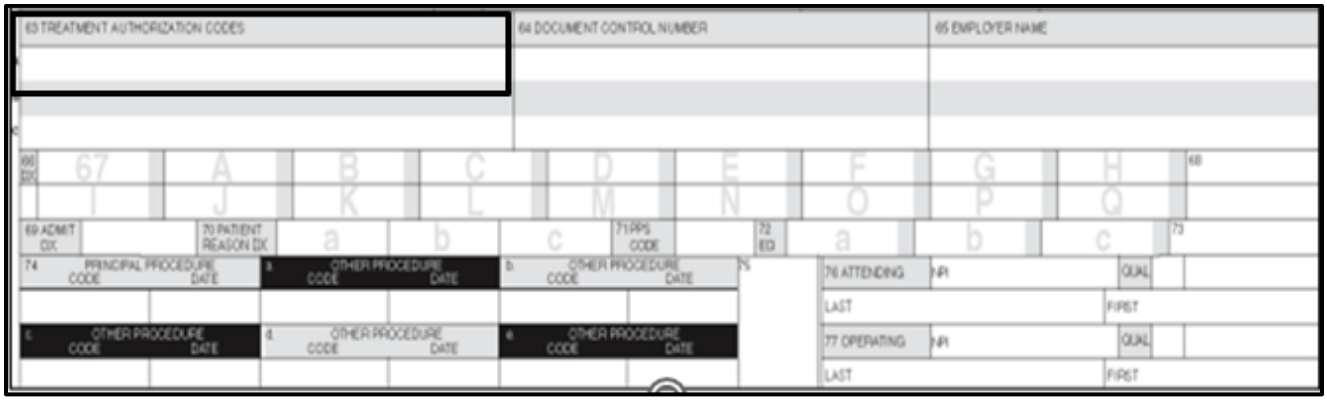


Figure 1.8: Treatment Authorization Codes.

Table of Form Items Descriptions (continued)

Item	Description
63a thru c	**Treatment Authorization Codes**. For services requiring a *Treatment Authorization Request* (TAR), enter the 11-digit TAR Control Number. It is not necessary to attach a copy of the TAR to the claim. Recipient information on the claim must match the TAR. Multiple claims must be submitted for services that have more than one TAR. Only one TAR Control Number can cover the services billed on any one claim. Be sure the billed dates fall within the TAR authorized dates. **Note**: Providers who obtain electronic TARs (eTARs) must enter a 10-digit TAR Control Number (TCN) and add a zero at the end as the 11th digit. Providers with a nine-digit paper TAR must add two zeroes at the end to complete the 11-digit TCN.
64a thru c	**Document Control Number**. Not required by Medi-Cal.
65a thru c	**Employer Name**. Not required by Medi-Cal.

Table of Form Items Descriptions (continued)

Item	Description
66	**Diagnosis Code Header**. For claims with dates of service/dates of discharge on or after October 1, 2015, enter the ICD indicator “0” in the white space below the *Diagnosis Code* field (Box 66). No ICD indicator is required if the claim is submitted without a diagnosis code.
67	**Unlabeled (Use for primary diagnosis code)**. Enter the Primary ICD-10-CM diagnosis code (*International Classification of Diseases – 10th Revision, Clinical Modification*). Enter all letters and/or numbers of the ICD-10-CM code for the primary diagnosis, including fourth through seventh digits if present. Do not enter a decimal point when entering the code. Present on admission (POA) indicator: Each diagnosis code may require a POA indicator that meets Centers for Medicare & Medicaid Services (CMS) standards. Enter POA indicators in the shaded area on the right side of Boxes 67 thru 67q. **Note**: The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67a.

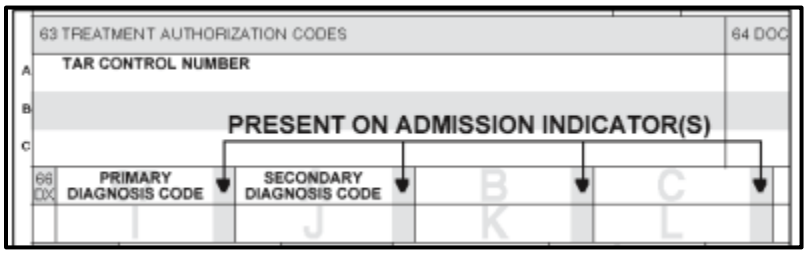


Figure 1.9: Arrows show shaded areas where Present on Admission (POA) indicators are placed, next their associated diagnosis codes.

Table of Form Items Descriptions (continued)

Item	Description
67a	**Unlabeled (Use for secondary diagnosis code)**. If applicable, enter all letters and/or numbers of the ICD-10-CM code for the secondary diagnosis, including fourth through seventh digits if present. Do not enter a decimal point when entering the code. Present on admission (POA) indicator: Each diagnosis code may require a POA indicator that meets CMS standards. Enter POA indicators in the shaded area on the right side of Boxes 67 thru 67Q. **Note**: The Medi-Cal claims processing system scans only the primary and secondary diagnosis codes entered in Boxes 67 and 67a.
67b thru q	**Unlabeled**. Not required by Medi-Cal. See “Note” in Item 67a.
68	**Unlabeled**. Not required by Medi-Cal.
69	**Admitting Diagnosis**. Not required by Medi-Cal.
70	**Patient Reason Diagnosis**. Not required by Medi-Cal.
71	**PPS code**. Not required by Medi-Cal.
72	**External Cause of Injury Code**. Not required by Medi-Cal.
73	**Unlabeled**. Not required by Medi-Cal.
74a thru e	**Other procedure codes and dates**. Not required by Medi-Cal.
75	**Unlabeled**. Not required by Medi-Cal.
76	**Attending**. In the first box, enter the attending physician’s NPI. Do not use a group provider number. The attending physician’s first and last name are not required by Medi-Cal. Be sure the attending physician’s NPI is entered on a(n): • Admit claim • Initial Medi-Cal claim for a Medicare/Medi-Cal crossover patient • Claim when there is a change in the attending physician’s provider number

Table of Form Items Descriptions (continued)

Item	Description
77	**Operating**. Not required by Medi-Cal.
78	**Other**. Not required by Medi-Cal.
79	**Other**. Not required by Medi-Cal.
80	**Remarks**. Use this area for procedures that require additional information, justification or an Emergency Certification Statement. The Emergency Certification Statement is required for all OBRA/IRCA recipients, and any service rendered under emergency conditions that would otherwise have required authorization, such as, emergency services by allergists, podiatrists, portable imaging providers, psychiatrists and out-of-state providers. These statements 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 the *Remarks* field (Box 80), attach the statement to the claim.
81a thru d	**Code-Code**. Not required by Medi-Cal.

Follow-Up

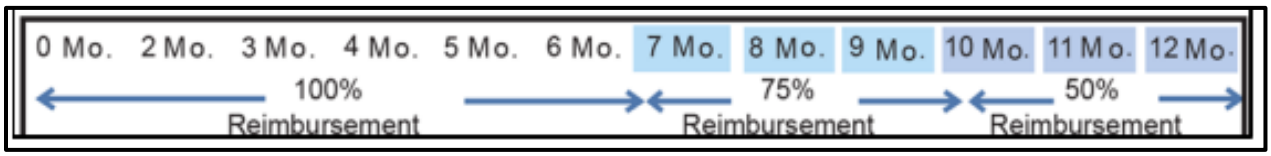
Claim Reminders

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.

Submission Timeline Guidelines

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.

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.



Claims submitted **after** the six-month billing limit and received by the California MMIS Fiscal Intermediary (FI), 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 receive 75% of the payable amount
- 10-12 months after the month of service will receive 50% of the payable amount
- Over 12 months with no valid delay reason code will be denied

Follow-Up Options

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:

- Rebill the claim (within 6 months following month of service
- Submit a *Claims Inquiry Form* (CIF) within 6 months from date of the RAD
- Submit an Appeal form within 90 days from date on RAD, *Claims Inquiry Response Letter* or *Claims Inquiry Acknowledgement*
- Contact the Correspondence Specialist Unit (CSU)

For more information on UB-04 Form Completion Guidelines, refer to UB-04 Claim Form workbook located on the Medi-Cal Providers website.

Knowledge Review

1. LTC providers can begin to use the *UB-04* claim form in February 2024.

   True □ False □

2. Providers need to complete each field on the *UB-04* Claim Form.

   True □ False □

3. The Crosswalks and FAQs provide valuable information regarding the LTC Code Conversion.

   True □ False □

4. When billing services on the LTC UB-04 claim form, you can bill for multiple recipients.

   True □ False □

5. Providers also have the option of submitting electronic LTC claims using the 837I claim transaction.

   True □ False □

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: Long Term Care Services

LTC Code and Claim Form Conversion: LTC 25-1 to UB-04 Claim Form Crosswalk

LTC Code and Claim Form Conversion: LTC Accommodation Code to Revenue Code, Value Code and Value Code Amount Crosswalk

LTC Code and Claim Form Conversion: LTC Patient Status Code to Patient Discharge Status Code Crosswalk

Other References

- Medi-Cal Providers website
- LTC Code and Claim Conversion: TAR, Crossover and Claim Completion Instructions
- LTC Code and Claim Form Conversion: Frequently Asked Questions (FAQs)
- Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual