



## Outpatient Services • Clinics and Hospitals

### April 2007 • Bulletin 390

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### New Claim Form Billing Instructions

To ensure that providers have the most current information available regarding the new *UB-04* claim form, the California Department of Health Services is releasing a preview of the provider manual claim form completion section *New UB-04 Sample and Instructions* and *NPI Dual-Use Period* instructions with this *Medi-Cal Update*.

**The preview, *New UB-04 Sample and Instructions*, is found at the end of the Part 2 bulletin. Retain these instructions until the May 2007 *Special Update* arrives.**

Providers are urged to read the claim form completion instructions immediately to understand how to bill using the new claim forms. Providers may begin using the new claim forms on April 23, 2007. Use of the new claim forms becomes mandatory on June 25, 2007.

Medi-Cal has instituted a provider number dual-use period from May 23, 2007 through November 25, 2007. During that time, providers must use their Medi-Cal provider number and, if available, also enter their NPI.

The guidelines for submitting proprietary claim forms will not change during the claim form transition period. For a complete list of forms, see the article, "Provider Number Dual-Use Period Begins May 23, 2007," in this bulletin.

### Mammography Billing Codes Correction

Two CPT-4 codes for diagnostic mammography (76090 and 76091) were inadvertently defined as screening mammography codes. Providers need take no action. Incorrectly denied claims for dates of service on or after December 1, 2006 will be reprocessed.

Effective retroactively for dates of service on or after December 1, 2006, the following HCPCS and CPT-4 codes are Medi-Cal mammography benefits.

#### Screening Mammography

<u>Code</u>	<u>Description</u>
G0202	Screening mammography, producing direct digital image, bilateral, all views
76092	Screening mammography, bilateral (two view film study of each breast)
76083	Computer aided detection with further physician review for interpretation, with or without digitization of film radiographic images; screening mammography

*Please see Correction, page 2*

## Correction (continued)

Screening mammograms are restricted to females. The following age and frequency restrictions apply:

- Younger than 35 years of age do not receive this benefit
- Ages 35 through 39 receive screening to establish a baseline; only one screening is reimbursable for women within this age range
- 40 years of age or older are restricted to one screening per year

### Diagnostic Mammography

<u>Code</u>	<u>Description</u>
G0204	Diagnostic mammography, producing direct digital image, bilateral, all views
G0206	unilateral, all views
76090	Mammography; unilateral
76091	bilateral
76082	Computer aided detection with further physician review for interpretation, with or without digitization of film radiographic images; diagnostic mammography

Diagnostic mammograms are reimbursable if one of the following applies:

- The recipient has distinct signs and symptoms for which a mammogram is indicated
- The recipient has a history of breast cancer; or
- The recipient is asymptomatic, but on the basis of the recipient's history and other significant factors in the physician's judgment, a diagnostic mammogram is indicated and appropriate

**Note:** The CAD mammography codes 76082 (diagnostic) and 76083 (screening) are used as an adjunct to film and digital mammography. Code 76082 may be billed with 76090, 76091, G0204 and G0206. Code 76083 may be payable with 76092 and G0202. Providers must list the CAD code separately to the primary procedure code.

### ICD-9-CM Code Requirements

Claims submitted for diagnostic mammograms must include one of the following ICD-9-CM diagnosis codes. Claims without a diagnosis code will be denied.

<u>ICD-9-CM Code</u>	<u>Description</u>
174.0 – 174.9	Malignant neoplasm of female breast
175.0 – 175.9	Malignant neoplasm of male breast
198.81	Secondary malignant neoplasm of other specified sites; breast
198.89	other
233.0 – 233.09	Carcinoma in situ of breast
238.3 – 238.39	Neoplasm of uncertain behavior of other and unspecified sites and tissues; breast
239.3 – 239.39	Neoplasms of unspecified nature; breast
V10.3 – V10.39	Personal history of malignant neoplasm; breast
V16.3 – V16.39	Family history of malignant neoplasm; breast
V76.10 – V76.19	Special screening for malignant neoplasms; breast

*This information is reflected on manual replacement pages [radi dia 25](#) and [26](#) (Part 2).*

**Cancer Detection Programs: Every Woman Counts  
2007 Poverty Level Income Guidelines**

The 2007 Federal Poverty Level Income Guidelines are effective April 1, 2007 through March 31, 2008. These guidelines are used to determine financial eligibility for applicants of Cancer Detection Programs: Every Woman Counts. Applicants are eligible if their gross family incomes are at or below the revised poverty levels shown in the following table.

**FEDERAL POVERTY INCOME GUIDELINES  
200 Percent of Poverty by Family Size**

<b>Family Members Living in Household</b>	<b>Monthly Gross Household Income</b>	<b>Annual Gross Household Income</b>
1	\$ 1,702	\$ 20,420
2	\$ 2,282	\$ 27,380
3	\$ 2,862	\$ 34,340
4	\$ 3,442	\$ 41,300
5	\$ 4,022	\$ 48,260
6	\$ 4,602	\$ 55,220
7	\$ 5,182	\$ 62,180
8	\$ 5,762	\$ 69,140
For each additional member, add:	\$ 580	\$ 6,960

“Gross Household Income” is the income before taxes and other deductions, and includes the income of family members living together

For additional Cancer Detection Programs: Every Woman Counts information, call the Telephone Service Center (TSC) at 1-800-541-5555.

*This information is reflected on manual replacement page can detect 8 (Part 2).*

**Automatic Crossover Claims for Critical Access Hospitals**

Effective immediately, outpatient crossover claims for Critical Access Hospitals may now cross over automatically from Medicare to Medi-Cal. Outpatient claims for these providers are identified by the facility type 85 and a corresponding claim frequency code in Box 4 on the *UB-92 Claim Form*. Outpatient claims provided by a Critical Access Hospital to recipients enrolled in a County Organized Health System (COHS) for services covered by the plan may also be forwarded automatically to the COHS for payment. Providers will not need to re-bill these claims to Medi-Cal or the COHS, but are advised to bill Medicare Part A with appropriate Medi-Cal modifiers for these services. The use of Medi-Cal modifiers, indicating either a technical (TC) or professional (26) component, will not affect Medicare processing, and will prevent certain duplicate claim denials when these secondary claims are processed by Medi-Cal.

**Updated Restrictions for Cranial Neurostimulators**

Effective May 1, 2007, CPT-4 codes 61867 and 61868 require a *Treatment Authorization Request* (TAR). Providers will no longer be required to bill the following cranial neurostimulator codes with a specific ICD-9-CM diagnosis code since all the codes require a TAR.

<u>CPT-4 Code</u>	<u>Description</u>
61867	Twist drill, burr hole, craniotomy, or craniectomy with stereotactic implementation of neurostimulator electrode array in subcortical site, with use of intraoperative microelectrode recording; first array
61868	each additional array
61880	Revision or removal of intracranial neurostimulator electrodes

*Please see Updated Restrictions, page 4*

## Updated Restrictions (continued)

<u>CPT-4 Code</u>	<u>Description</u>
61885	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode ray
61886	with connection to two or more electrode rays
61888	Revision or removal of cranial neurostimulator pulse generator or receiver

*Updated information is reflected on manual replacement pages surg nerv 3, 5 and 11 (Part 2) and tar and non cd6 1 (Part 2).*

### **Diagnosis Code Now Requires Five Digits for Billing**

Effective immediately, ICD-9-CM diagnosis code 659.7 (abnormality in fetal heart rate or rhythm) must be billed using a fifth digit – 659.70, 659.71 or 659.73. Claims billed with ICD-9-CM diagnosis code 659.7 to only the fourth digit will be denied.

For dates of service on or after January 1, 2001, claims that were previously inappropriately denied when billing 659.7 to the fifth digit will be automatically reprocessed.

### **Additional Codes Reimbursable for Services Rendered by NMPs**

Effective for dates of service on or after May 1, 2007, the following CPT-4 surgery codes are payable to a Medi-Cal provider when rendered by a Non-physician Medical Practitioner (NMP):

54050	56420	56515	57061	57454	57456
54065	56501	56605	57065	57455	57505

An NMP is defined as a nurse practitioner, physician assistant or certified nurse midwife.

*This information is reflected on manual replacement page non ph 6 (Part 2).*

### **Presumptive Eligibility Code Update**

Effective for dates of service on or after May 1, 2007, CPT-4 code 88150 (cytopathology, slides, cervical or vaginal; manual screening under physician supervision) will be replaced with code 88164 (cytopathology, slides, cervical or vaginal [the Bethesda System]; manual screening under physician supervision) for the Presumptive Eligibility (PE) program. The Bethesda System is the current standard for gynecological cytology reporting.

*This information is reflected on manual replacement page presum 18 (Part 2).*

### **Presumptive Eligibility Program 2007 Poverty Level Income Guidelines**

The 2007 Federal Poverty Income Guidelines are effective April 1, 2007 through March 31, 2008. The guidelines are used to determine eligibility for Presumptive Eligibility (PE) program services for pregnant women. Applicants are eligible if their gross family income is at or below the revised poverty levels shown in the following table. The applicant's unborn child is counted as a member of the family; therefore, the guidelines begin with two persons (the mother and her unborn child). For additional PE information, call the Telephone Service Center (TSC) at 1-800-541-5555.

*Please see **Presumptive Eligibility**, page 5*

**FEDERAL POVERTY INCOME GUIDELINES**  
200 Percent of Poverty by Family Size

Number of Persons	Gross Monthly Income	Gross Annual Income
2	\$ 2,282	\$ 27,380
3	\$ 2,862	\$ 34,340
4	\$ 3,442	\$ 41,300
5	\$ 4,022	\$ 48,260
6	\$ 4,602	\$ 55,220
7	\$ 5,182	\$ 62,180
8	\$ 5,762	\$ 69,140
9	\$ 6,342	\$ 76,100
10	\$ 6,922	\$ 83,060
For each additional person, add	\$ 580	\$ 6,960

This updated information is reflected on manual replacement page presum 6 (Part 2).



**Provider Orientation and Update Session**

Medi-Cal providers seeking enrollment in the Family PACT (Planning, Access, Care and Treatment) Program are required to attend a Provider Orientation and Update Session. The date for an upcoming session is listed below.

Individual and group providers wishing to enroll must send a physician-owner to the session. Clinics wishing to enroll must send the medical director or clinician responsible for oversight of medical services rendered in connection with the Medi-Cal provider number.

Office staff members, such as clinic managers, billing supervisors and patient eligibility enrollment supervisors, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain current with program policies and services. Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Please note the upcoming Provider Orientation and Update Session below.

**Oakland**  
**June 7, 2007**  
**8:30 a.m. – 4:30 p.m.**  
Park Plaza Hotel  
150 Hegenberger Road  
Oakland, CA 94621  
(510) 635-5000

For a map and directions to this location, go to the Family PACT Web site ([www.familypact.org](http://www.familypact.org)) and click “Providers” at the top of the home page, then “Provider Training,” and finally, click the appropriate location.

**Registration**

To register for an orientation and update session, go to the Family PACT Web site ([www.familypact.org](http://www.familypact.org)) and click “Providers” at the top of the home page, then “Provider Training,” and finally, click the “Registration” link next to the appropriate date and location and print a copy of the registration form.

*Please see Update Session, page 6*

## Update Session *(continued)*

Fill out the form and fax it to the Office of Family Planning, ATTN: Darleen Kinner, at (916) 650-0468. If you do not have Internet access, you may request the registration form by calling 1-877-FAMPACT (1-877-326-7228).

Providers must supply the following when registering:

- Name of the Medi-Cal provider or facility
- Medi-Cal provider number
- Contact telephone number
- Anticipated number of people attending

### Check-In

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. At the session, providers must present the following:

- Medi-Cal provider number
- Medical license number
- Photo identification

**Note:** Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not an individual provider number or license number.

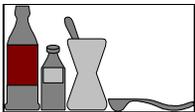
### Certificate of Attendance

Upon completion of the orientation session, each prospective new Family PACT medical provider will receive a *Certificate of Attendance*. Providers should include the original copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services. Providers arriving late or leaving early will not receive a *Certificate of Attendance*. Currently enrolled Family PACT providers do not receive a certificate.

### Contact Information

For more information about the Family PACT Program, please call 1-877-FAMPACT (1-877-326-7228) or visit the Family PACT Web site ([www.familypact.org](http://www.familypact.org)).

*The Family PACT Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.*



## DRUG USE REVIEW *Educational Information*

### DUR Target Drug List

Effective May 1, 2007, Etanercept will be removed from the Drug Use Review (DUR) Target Drug List and DUR screenings will be limited to Early Refill (ER) and Drug-Drug Interaction (DD).

### CCS Service Code Groupings Update

Retroactive for dates of service on or after November 1, 2006, a number of codes are added to California Children's Services (CCS) Service Code Groupings (SCGs) 01, 02, 03, 07 and 09.

Effective retroactively for dates of service on or after July 1, 2004, new SCG 12 is added for Podiatry.

HCPCS code J0885 was inadvertently added to SCG 09. It is only included in SCGs 01, 02, 03 and 07.

**Reminder:** SCG 02 includes all the codes in SCG 01; SCG 03 includes all the codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01. These same "rules" apply to end-dated codes.

*The updated information is reflected on manual replacement pages cal child ser 1, 5, 11 thru 13, 22 and 24 thru 27 (Part 2).*

# NPI Dual-Use Period

**May 23, 2007 through November 25, 2007**

Follow these simple rules, and your *UB-04* claims will pass the provider identifier test! You **must** use a Medi-Cal provider number. You **may** also include an NPI in the following boxes of the claim. (Claims received with *only* an NPI will **not** be processed.)

		23
56 NPI		A
57		B
OTHER		
PRV ID		
62 INSURANCE GROUP NO.		

## BOXES 56 and 57

Enter the billing provider's NPI in **Box 56** and Medi-Cal provider number in **Box 57**.

**BOXES 76 through 78:** Enter the appropriate provider's NPI in the box labeled "NPI." In the "QUAL" fields, enter "1D" in the first box and the Medi-Cal number in the next box. The provider's first and last names are not necessary.

For **Outpatient** billers, Box 76 is for the referring or prescribing physician, and Box 77 is for the rendering physician. Box 78 is not required.

For **Inpatient** billers, Box 76 is for the attending physician, Box 77 is for the operating physician, and Box 78 is any other necessary physician provider numbers. See specific claim examples for details.

		a	b	c	73
76 ATTENDING	NPI			QUAL	
LAST				FIRST	
77 OPERATING	NPI			QUAL	
LAST				FIRST	
78 OTHER	NPI			QUAL	
LAST				FIRST	



## Explanation of Form Items

The following item numbers and descriptions correspond to the *UB-04* claim form on the previous page. All items must be completed unless otherwise noted.

**Note:** Items described as “Not required by Medi-Cal” may be completed for other payers, but are not recognized by the Medi-Cal claims processing system.

- | <u>Item</u> | <u>Description</u>  |
|-------------|---|
| 1.          | <b>UNLABELED (Use for clinic or facility information).</b> Enter the clinic or 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.   |
| 2.          | <b>UNLABELED.</b> For FI use only. This field must be left blank on all claims submitted to Medi-Cal.   |
| 3A.         | <b>PATIENT CONTROL NUMBER.</b> This is an optional field that will help you to easily identify a recipient on <i>Resubmission Turnaround Documents (RTDs)</i> and <i>Remittance Advices (RAs)</i> . 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 RTD and RA. Refer to the <i>Remittance Advice Details (RAD) Examples: Outpatient Services</i> section in this manual for patient control number information. |
| 3B.         | <b>MEDICAL RECORD NUMBER.</b> Not required by Medi-Cal. Use Box 3A to enter a patient control number. This number will not appear on the RTD or RA for recipient clarification. The patient control number (Item 3) will appear on the RTD and RA.  |
| 4.          | <b>TYPE OF BILL.</b> Enter the appropriate three-character type of bill code as specified in the <i>National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual</i> . The type of bill code includes the two-digit facility type code and one-character claim frequency code. 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* facility type codes commonly used by Medi-Cal.

Use one of the following codes as the first two digits of the three-character type of bill code:

<u>Code</u>	<u>Facility Type</u>
11	Hospital – Inpatient (Including Medicare Part A)
12	Hospital – Inpatient (Medicare Part B only)
13	Hospital – Outpatient
14	Hospital – Other (For hospital referenced diagnostic services, or home health not under a plan of treatment). Use admit type “1” when billing for emergency services.
24	Skilled Nursing – Clinic (For hospital referenced diagnostic services, or home health not under a plan of treatment)

<u>Item</u>	<u>Description</u>
4.	<b>TYPE OF BILL. (continued)</b>
	<u>Code</u> <u>Facility Type</u>
	25      Skilled Nursing – Intermediate Care Level II (Level A)
	26      Skilled Nursing – Intermediate Care Level II (Level B)
	27      Skilled Nursing – Subacute (Use modifier HB to indicate adult or HA to indicate child)
	33      Home Health – Outpatient
	34      Home Health – Other (For hospital referenced diagnostic services, or home health not under a plan of treatment)
	44      Religious Non-Medical Health Care Institutions, Hospital Inpatient – Other (For hospital referenced diagnostic services, or home health not under a plan of treatment)
	54      Religious Non-Medical Health Care Institutions, Post Hospital Extended Care Services – Other (For hospital referenced diagnostic services, or home health not under a plan of treatment)
	64      Intermediate Care – Other (For hospital referenced diagnostic services or home health not under a plan of treatment)
	65      Intermediate Care – Intermediate Care Level I
	71      Clinic – Rural Health
	72      Clinic – Hospital Based or Independent Renal Dialysis Center
	73      Clinic – Free Standing
	74      Clinic – Outpatient Rehabilitation Facility (ORF)
	75      Clinic – Comprehensive Outpatient Rehabilitation Facility (CORF)
	76      Clinic – Community Mental Health Center
	79      Clinic – Other
	81      Special Facility – Hospice (non-hospital based)
	83      Special Facility – Ambulatory Surgery Center
	86      Special Facility – Residential Facility
	89      Special Facility – Other

**Notes:** Only one facility type may be billed on each claim. Outpatient services not logically compatible with the facility type identified on the claim must be billed on a separate claim.

Clinics and outpatient hospitals use one of the following codes as the first two digits of the three-character type of bill code:

<u>Provider Type</u>	<u>Facility Type</u>
AIDS Waiver Agency	13, 33, 79
Chronic Dialysis Clinic	72
Community Hospital, Outpatient	13
Community Mental Health Clinic	76
Employer/Employee Clinic	79
Exempt from Licensure Clinic	79
Free Clinic	79

4. **TYPE OF BILL. (continued)**

<u>Provider Type</u>	<u>Facility Type</u>
Home Health Agency	33
Local Educational Agency	89
Multispecialty Clinic	79
Rehab Clinic	74
Rehab Clinic (Comprehensive)	75
Rural Health Clinic	71
Surgical Clinic	73, 79

5. **FEDERAL TAX NUMBER.** Not required by Medi-Cal.

6. **STATEMENT COVERS PERIOD (From-Through).** Not required by Medi-Cal.

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.

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" (example: Jones, Baby Girl). If billing for newborn infants from a multiple birth, each newborn must also be designated by number or letter (example: Jones, Baby Girl, Twin A) on separate claims.

Enter the infant's date of birth and sex in Boxes 10 and 11. Enter the mother's name in Box 58 (*Insured's Name*), and enter "03" (CHILD) in Box 59 (*Patient's Relationship to Insured*).

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 Box 58 (*Insured's Name*) and enter "11" (DONOR) in Box 59 (*Patient's Relationship to Insured*).

9A-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. (For newborns and organ donors, see Item 8B.)

11. **SEX.** Use the capital letter "M" for male, or "F" for female. Obtain the sex indicator from the Benefits Identification Card. (For newborns and organ donors, see Item 8B on a previous page.)

12. **ADMISSION DATE.** Not required by Medi-Cal.

13. **ADMISSION HOUR.** Not required by Medi-Cal.

<u>Item</u>	<u>Description</u>
14.	<b>ADMISSION TYPE.</b> Enter admit type code “1” in conjunction with facility type “14” when billing for emergency room-related services. Not required by Medi-Cal for any other use. See “Emergency Certification” under Condition Codes (Items 18 – 24) on a following page for additional information.
15.	<b>ADMISSION SOURCE.</b> Not required by Medi-Cal.
16.	<b>DISCHARGE HOUR.</b> Not required by Medi-Cal.
17.	<b>STATUS.</b> Not required by Medi-Cal.
18 – 24.	<b>CONDITION CODES.</b> 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. <u>The claims processing system ignores all codes not applicable to Medi-Cal.</u>

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 other coverage and is identified separately.

Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient’s other health insurance 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” if 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 all OBRA/IRCA recipients and any service rendered under emergency conditions that would otherwise have required prior authorization such as emergency services by allergists, podiatrists, medical transportation providers, portable X-ray 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) area, attach the statement to the claim.

Item      Description

18 – 24.      **CONDITION CODES (continued).**

Outside Laboratory: Enter code “82” if this claim includes charges for laboratory work performed by a licensed laboratory. “Outside” laboratory (facility type “89”) refers to a laboratory not affiliated with the billing provider. State in the *Remarks* field (Box 80) that a specimen was sent to an unaffiliated laboratory.

Family Planning/CHDP: Enter code “A1” or “A4” if the services rendered are related to Family Planning (FP). Enter code “A1” if the services rendered are Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Child Health and Disability Prevention (CHDP) screening related. Leave blank if not applicable.

<u>Code</u>	<u>Description</u>
A1	EPSDT/CHDP
A4	Family Planning
A1	Sterilization/Sterilization <i>Consent Form</i> (PM 330) must be attached if code “A1” is entered

See *Family Planning* and *Sterilization* sections in the appropriate Part 2 manual for further information.

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 – 24) blank. The Medicare status codes are:

<u>Code</u>	<u>Description</u>
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

\* Documentation required. Refer to the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section in the appropriate Part 2 manual for more information.

- Item      Description
- 25 – 28.    **CONDITION CODES.** The Medi-Cal claims processing system only recognizes condition codes entered in Boxes 18 – 24.
29.        **ACDT STATE.** Not required by Medi-Cal.
30.        **UNLABELED.** Not required by Medi-Cal.
- 31 – 34 A – 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. Refer to the illustration below.

	31	32	33	34	35
	OCCURRENCE CODE	OCCURRENCE DATE	OCCURRENCE CODE	OCCURRENCE DATE	OCCURRENCE CODE
a	05	060907	24	060907	
b					
	38				

Occurrence Codes Example.

Although the Medi-Cal claims processing system will only recognize the following codes, providers may include codes and dates billed to other payers in Boxes 31 – 34. The claims processing system will ignore all codes not applicable to Medi-Cal.

Applicable Medi-Cal codes are:

Enter code "04" (accident/employment-related) in Boxes 31 through 34 if the accident or injury was employment related. Enter one of the following codes if the accident or injury was non-employment related:

<u>Code</u>	<u>Description</u>
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

In six-digit MMDDYY (Month, Day, Year) format, enter the date of accident/injury in the corresponding box.

- 35 – 36 A – B.    **OCCURRENCE SPAN CODES AND DATES.** Not required by Medi-Cal.

Item      Description

37A.      **UNLABELED (Use for delay reason codes).** Enter one of the following delay reason codes and include the required documentation if there is an exception to the six-months-from-the-month-of-service billing limit.

<u>Code</u>	<u>Description</u>	<u>Documentation</u>
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

\* 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.

Also refer to the *UB-04 Submission and Timeliness Instructions* section for additional information about codes and documentation requirements.

37B.      **UNLABELED.** Not required by Medi-Cal.

38.      **UNLABELED.** Not required by Medi-Cal.

39 – 41 A – D.      **VALUE CODES AND AMOUNT. 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. For example, 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. (See illustration on a following page.)

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 – 41. The claims processing system will ignore all codes not applicable to Medi-Cal.

Item      Description

39 – 41 A – D.      **VALUE CODES AND AMOUNT. Patient’s Share of Cost. (continued)**

Enter code “23” and the amount of the patient’s Share of Cost 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 Outpatient Services* section in this manual.

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

Value Codes Example.

42.      **REVENUE CODE.** Revenue codes are not required by Medi-Cal.

**Total Charges:** Enter “001” on line 23, and enter the total amount on line 23, field 47.

43.      **DESCRIPTION.** This optional field will help you separate and identify the descriptions of each service. The description must identify the particular service code indicated in the *HCPCS/Rate/HIPPS Code* field (Box 44). For more information, refer to the CPT-4 code book.

**Note:** If there are multiple pages of the claim, enter the page numbers on line 23 in this field.

44.      **HCPCS/RATE/HIPPS CODE.** Enter the applicable procedure code (CPT-4 or HCPCS) and modifier(s). 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-4 codes are listed in the *TAR and Non-Benefit List: Codes (10000 – 99999)* sections in the appropriate Part 2 manual.

Up to four modifiers may be entered on outpatient *UB-04* claims. All modifiers must be billed immediately following the HCPCS code in the *HCPCS/Rate* field (Box 44) with no spaces.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1	<b>EMERGENCY ROOM USE</b>	<b>Z7501TC90AB21</b>	<b>060207</b>	<b>2</b>	<b>230000</b>
2					
3					
4					

*UB-04* Claim: Codes and Modifiers Example.

Item      Description

44.      **HPCS/RATE/HIPPS CODE. (continued)**

Medicare/Medi-Cal  
Recipients

If billing for services to a recipient with both Medicare and Medi-Cal, refer to the *Medicare Non-Covered Services* sections in the appropriate Part 2 Outpatient Services manual to check the list of Medicare non-covered services codes. Only those services listed in a *Medicare Non-Covered Services* section may be billed directly to Medi-Cal. All others must be billed to Medicare first.

For a listing of modifier codes, refer to the *Modifiers: Approved List* section in the appropriate Part 2 manual.

45.      **SERVICE DATE.** Enter the date the service was rendered in six-digit, MMDDYY (Month, Day, Year) format, for example, June 24, 2003 = 062403.

“From-Through” Billing

For “From-Through” billing instructions, refer to the *UB-04 Special Billing Instructions for Outpatient Services* section in this manual.

46.      **SERVICE UNITS.** Enter the actual number of times a single procedure or item was provided for the date of service. Medi-Cal only allows two digits in this field. If billing for more than 99, divide the units on 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 amount is even (for example, if billing for \$100, enter 10000 not 100). If an item is a taxable medical supply, include the applicable state and county sales tax.

**Note:** Medi-Cal cannot process credits or adjustments on the *UB-04* form. Refer to the *CIF Completion* and *CIF Special Billing Instructions for Outpatient Services* sections in the appropriate Part 2 manual 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 – 49). It is also acceptable to skip lines.

To delete a line, mark through the boxes as shown in the following illustration. Be sure to draw a thin line through the entire detail line using a blue or black ballpoint pen.

Item Description

49. UNLABELED (continued)

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1	EMERGENCY ROOM USE	Z7501	060207	2	230000
2	EMERGENCY ROOM USE	Z7502	060207	2	230000
3	PANEL TEST	80018TC	060207	1	8000
4	AMINO ACID NITROGEN	8212690	060207	1	10000

UB-04 Claim: Line Deletion Example.

50A – C. **PAYER NAME.** Enter “O/P MEDI-CAL” to indicate the type of claim and payer. Use capital letters only. Refer to illustration below.

When completing Boxes 50 – 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.

When billing other insurance, the other insurance is entered on Line A of Box 50, with the amount paid by Other Coverage on Line A of Box 54 (*Prior Payments*). All information related to the Medi-Cal billing is entered on Line B of these boxes. Be sure to enter the corresponding prior payments on the correct line.

If Medi-Cal is the only payer billed, all information in Boxes 50 – 65 (excluding Box 56) should be entered on Line A.

**Reminder:** If the recipient has Other Health Coverage, the insurance carrier must be billed prior to billing Medi-Cal.

001	PAGE	OF
PAYER NAME		
O/P MEDI-CAL		

UB-04 Claim: Payer Name Example.

51A – C. **HEALTH PLAN ID.** Not required by Medi-Cal.

52A – C. **RELEASE OF INFORMATION CERTIFICATION INDICATOR.** Not required by Medi-Cal.

53A – C. **ASSIGNMENT OF BENEFITS CERTIFICATION INDICATOR.** Not required by Medi-Cal.

- | <u>Item</u>                                  | <u>Description</u>  |               |                              |                      |   |  |  |
|--|---|---------------|------------------------------|----------------------|---|--|--|
| 54A – B.                                     | <p><b>PRIOR PAYMENTS (Other Coverage).</b> 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.</p> <p><b>Note:</b> For instructions about completing this field for Medicare/Medi-Cal crossover recipients, refer to the <i>Medicare/Medi-Cal Crossover Claims: Outpatient Services</i> section in this manual.</p>   |               |                              |                      |   |  |  |
| 55A – C.                                     | <p><b>ESTIMATED AMOUNT DUE (Net amount billed).</b> 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 (\$).</p> <table border="0" style="margin-left: 40px;"> <tr> <td style="text-align: right;">Total Charges</td> <td style="text-align: right;">(Box 47) Revenue code<br/>001</td> </tr> <tr> <td style="text-align: right;">(Minus) – Deductions</td> <td style="text-align: right;">Share of Cost (Box 39, 40<br/>or 41A – D/ Value code<br/>23) and Other Coverage<br/>(Box 54A or B)</td> </tr> <tr> <td colspan="2" style="text-align: right;">(Equals) = <u>Net Billed</u> (Boxes 55A – C)</td> </tr> </table> | Total Charges | (Box 47) Revenue code<br>001 | (Minus) – Deductions | Share of Cost (Box 39, 40<br>or 41A – D/ Value code<br>23) and Other Coverage<br>(Box 54A or B) | (Equals) = <u>Net Billed</u> (Boxes 55A – C) |  |
| Total Charges                                | (Box 47) Revenue code<br>001  |               |                              |                      |   |  |  |
| (Minus) – Deductions                         | Share of Cost (Box 39, 40<br>or 41A – D/ Value code<br>23) and Other Coverage<br>(Box 54A or B)   |               |                              |                      |   |  |  |
| (Equals) = <u>Net Billed</u> (Boxes 55A – C) |   |               |                              |                      |   |  |  |
| 56.  | <p><b>NPI.</b> Enter the National Provider Identifier (NPI).</p>  |               |                              |                      |   |  |  |
| 57A – C.                                     | <p><b>OTHER (BILLING) PROVIDER ID (Used by atypical providers only).</b> Enter the Medi-Cal provider number, corresponding to information on lines A, B or C.</p> <p><b>Note:</b> 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.</p>  |               |                              |                      |   |  |  |
| 58A – C.                                     | <p><b>INSURED’S NAME.</b> 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 (<i>Patient’s Relationship to Insured</i>). See Item 8B on a previous page. This box is not required by Medi-Cal except under the two circumstances listed in Item 8B.</p>  |               |                              |                      |   |  |  |
| 59A – C.                                     | <p><b>PATIENT’S RELATIONSHIP TO INSURED.</b> 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. This box is not required by Medi-Cal except under the two circumstances listed in Item 8B.</p>   |               |                              |                      |   |  |  |

	<u>Item</u>	<u>Description</u>
Newborn Infant	60A – C.	<b>INSURED’S UNIQUE ID.</b> Enter the 14-character recipient ID number as it appears on the Benefits Identification Card (BIC) or paper Medi-Cal ID card.  <b>Note:</b> Medi-Cal does not accept HIC Numbers.
		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 on a previous page.)
	61A – C.	<b>GROUP NAME.</b> Not required by Medi-Cal.
	62A – C.	<b>INSURANCE GROUP NUMBER.</b> Not required by Medi-Cal.
	63A – C.	<b>TREATMENT AUTHORIZATION CODES.</b> For services requiring a <i>Treatment Authorization Request</i> (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.  <b>Note:</b> TAR and non-TAR procedures should not be combined on the same claim.
	64A – C.	<b>DOCUMENT CONTROL NUMBER.</b> Not required by Medi-Cal.
	65A – C.	<b>EMPLOYER NAME.</b> Not required by Medi-Cal.
	66.	<b>DIAGNOSIS CODE HEADER.</b> Not required by Medi-Cal.
	67.	<b>UNLABELED (Use for primary diagnosis code).</b> Enter all letters and/or numbers of the ICD-9-CM code for the primary diagnosis, including fourth and fifth digits if present. Do not enter a decimal point when entering the code.
	67A.	<b>UNLABELED (Use for secondary diagnosis code).</b> If applicable, enter all letters and/or numbers of the secondary ICD-9-CM code, including fourth and fifth digits if present. Do not enter a decimal point when entering the code.
	67B – Q.	<b>UNLABELED.</b> Not required by Medi-Cal.
	68.	<b>UNLABELED.</b> Not required by Medi-Cal.
	69.	<b>ADMITTING DIAGNOSIS.</b> Not required by Medi-Cal.
	70.	<b>PATIENT REASON DIAGNOSIS.</b> Not required by Medi-Cal.
	71.	<b>PPS CODE.</b> Not required by Medi-Cal.
	72.	<b>EXTERNAL CAUSE OF INJURY CODE.</b> Not required by Medi-Cal.

<u>Item</u>	<u>Description</u>
73.	<b>UNLABELED.</b> Not required by Medi-Cal.
74.	<b>PRINCIPAL PROCEDURE CODE AND DATE.</b> Not required by Medi-Cal.
74A – E.	<b>OTHER PROCEDURE CODE AND DATE.</b> Not required by Medi-Cal.
75.	<b>UNLABELED.</b> Not required by Medi-Cal.
76.	<b>ATTENDING.</b> In the <i>NPI</i> box, enter the referring or prescribing physician’s NPI. For atypical referring or prescribing physicians, enter the Medicaid Identifier “1D” in the <i>Qual ID</i> box and the Medi-Cal provider number next to it. Do not use a group provider number. The referring or prescribing physician’s first and last name are not required by Medi-Cal.
77.	<b>OPERATING.</b> In the <i>NPI</i> box, enter the rendering physician’s NPI. For atypical rendering physicians, enter the Medicaid Identifier “1D” in the <i>Qual ID</i> box and the Medi-Cal provider number next to it. Do not use a group provider number. The admitting physician’s first and last name are not required by Medi-Cal.
78.	<b>OTHER.</b> Not required by Medi-Cal.
79.	<b>OTHER.</b> Not required by Medi-Cal.
80.	<b>REMARKS.</b> 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 prior authorization, such as, emergency services by allergists, podiatrists, medical transportation providers, portable X-ray 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 <i>Remarks</i> field (Box 80), attach the statement to the claim.
81A – D.	<b>CODE-CODE.</b> Not required by Medi-Cal.

**Clinics and Hospitals Bulletin 390**

Remove and replace: cal child ser 1/2, 5/6, 11 thru 14

Remove: cal child ser 21 thru 24

Insert: cal child ser 21 thru 27

Remove and replace: can detect 7/8  
non ph 5/6  
presum 5/6, 17/18  
radi dia 25/26  
surg nerv 3 thru 6, 11/12  
tar and non cd6 1/2

The "Instructions for Manual Replacement Pages" in the March *Medi-Cal Update* incorrectly instructed providers to remove and replace path hema ex 1/2. This section is not part of the Part 2 manual, *Clinics and Hospitals*, and should be removed.