



# MEDI-CAL UPDATE

## Part 2

Billing and Policy

[www.medi-cal.ca.gov](http://www.medi-cal.ca.gov)

### Medical Services • General Medicine

#### April 2007 • Bulletin 393

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#### New Claim Form Billing Instructions

To ensure that providers have the most current information available regarding the new *CMS-1500* claim form, the California Department of Health Services is releasing a preview of the provider manual claim form completion section *New CMS-1500 Sample and Instructions* and *NPI Dual-Use Period* instructions with this *Medi-Cal Update*.

**The preview, *New CMS-1500 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).*

## 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).*

## Dental Benefits for Pregnant Women

On October 7, 2005, the Governor signed SB 377, which directed the California Department of Health Services (CDHS) to immediately provide coverage of certain non-emergency dental benefits, described below, for pregnant Medi-Cal recipients. Prior to enactment of this legislation, these benefits were only available to pregnant women in the following restricted aid codes: 44, 48, 5F and 58 (see the November 2002 *Medi-Cal Update* and *Denti-Cal Bulletin*, Vol. 18, No. 19, October 2002).

Enactment of SB 377 requires immediate implementation of these same benefits for pregnant women in the following fifteen *additional* existing aid codes: 0U, 0V, 3T, 3V, 55, 5J, 5R, 5T, 5W, 6U, 7C, 7G, 7K, 7N and 8T (see *Denti-Cal Bulletin*, Vol. 21, No. 41, December 2005). These benefits were added because of recent scientific evidence showing an association between periodontal disease in pregnant women and adverse birth outcomes. **These benefits may help prevent pre-term delivery and low birth weight; they are important for the health of both the mother and the newborn. If a pregnant patient is not currently under the care of a dentist, providers are encouraged to refer her to one during her pregnancy.**

### Billing Update for FQHC, RHC and IHS Recipients

With respect to the dental services listed below that are provided to pregnant women in the fifteen additional aid codes by Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) or Indian Health Services (IHS), EDS will automatically reprocess and adjust denied claims with the above-mentioned criteria retroactive to dates of service on or after October 7, 2005.

The following aid codes are now eligible for this expanded coverage:

Code	Benefits	SOC	Program/Description
0U	Restricted Services	No	<p>BCCTP – Undocumented Aliens. Provides emergency, pregnancy-related and Long Term Care (LTC) services to females younger than 65 years of age with unsatisfactory immigration status who have been diagnosed with breast and/or cervical cancer. Does not cover individuals with creditable insurance. State-funded cancer treatment services are covered every 18 months (breast) and 24 months (cervical).</p> <p><i>Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).</i></p>

*Please see Dental Benefits, page 4*

**Dental Benefits** (continued)

<b>Code</b>	<b>Benefits</b>	<b>SOC</b>	<b>Program/Description</b>
0V	Restricted services	No	Post-BCCTP. Provides limited-scope no SOC Medi-Cal emergency, pregnancy-related and Long Term Care (LTC) services for females younger than 65 years of age with unsatisfactory immigration status and without creditable health insurance coverage who have exhausted their 18-month (breast) or 24-month (cervical) period of cancer treatment coverage under aid code 0U. No cancer treatment. Continues as long as the woman is in need of treatment and, other than immigration, meets all other eligibility requirements.  <i>Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).</i>
3T	Restricted to pregnancy and emergency services	No	Initial Transitional Medi-Cal (TMC). Provides six months of coverage for eligible aliens without satisfactory immigration status who have been discontinued from Section 1931(b) due to increased earnings from employment.
3V	Restricted to pregnancy and emergency services	No	AFDC – 1931(b) Non CalWORKS. Covers those eligible for the Section 1931(b) program who do not have satisfactory immigration status.
44	Restricted to Pregnancy-related services	No	200 Percent FPL Pregnant (Income Disregard Program – Pregnant). Provides eligible pregnant women of any age with family planning, pregnancy-related and postpartum services if family income is at or below 200 percent of the federal poverty level.
48	Restricted to pregnancy-related services	No	200 Percent FPL Pregnant Omnibus Budget Reconciliation Act (OBRA) (Income Disregard Program – Pregnant OBRA). Provides eligible pregnant aliens of any age without satisfactory immigration status with family planning, pregnancy-related and postpartum, if family income is at or below 200 percent of the federal poverty level.
5F	Restricted to pregnancy and emergency services	Y/N	OBRA Alien – Pregnant Woman. Covers eligible pregnant alien women who do not have satisfactory immigration status.
5J	Restricted to pregnancy and emergency services	No	SB 87 Pending Disability Program.
5R	Restricted to pregnancy and emergency services	Yes	SB 87 Pending Disability Program.
5T	Restricted to pregnancy and emergency services	No	Continuing TMC. Provides an additional six months of emergency services coverage for those beneficiaries who received six months of initial TMC coverage under aid code 3T.

Please see **Dental Benefits**, page 5

**Dental Benefits** (continued)

<b>Code</b>	<b>Benefits</b>	<b>SOC</b>	<b>Program/Description</b>
5W	Restricted to pregnancy and emergency services	No	Four-Month Continuing Pregnancy and Emergency Services Only. Provides four months of emergency services for aliens without satisfactory immigration status who are no longer eligible for Section 1931(b) due to the collection or increased collection of child/spousal support.
55	Restricted to pregnancy and emergency services	No	OBRA Not PRUCOL – Long Term Care (LTC) services. Covers eligible undocumented aliens in LTC who are not PRUCOL. Recipients will remain in this aid code even if they leave LTC. For more information about LTC services, refer to the <i>OBRA and IRCA</i> section in this manual.  <i>Providers Note: Long Term Care services refers to both those services included in the per diem base rate of the LTC provider, and those medically necessary services required as part of the patient's day-to-day plan of care in the LTC facility (for example, pharmacy, support surfaces and therapies).</i>
58	Restricted to pregnancy and emergency services	Y/N	OBRA Aliens. Covers eligible aliens who do not have satisfactory immigration status.
6U	Restricted to pregnancy and emergency services	No	Restricted Federal Poverty Level – Disabled. Covers the disabled in the Aged and Disabled FPL program who do not have satisfactory immigration status.
7C	Restricted to pregnancy and emergency services	No	100 Percent OBRA Child. Covers emergency and pregnancy-related services to otherwise eligible children, without satisfactory immigration status who are ages 6 to 19, or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.
7G	Valid only for ambulatory prenatal care services	No	Presumptive Eligibility (PE) – Ambulatory Prenatal Care. This option allows the Qualified Provider (QP) to make a determination of PE for outpatient prenatal care services based on preliminary income information. 7G is valid for Ambulatory Prenatal Care Services. Persons placed in 7G have pregnancy test results that are positive. QP issues paper PE ID Card.
7K	Restricted to pregnancy and emergency services	No	Continuous Eligibility for Children (CEC). Provides emergency and pregnancy-related benefits (no Share of Cost) to children without satisfactory immigration status who are up to 19 years of age who would otherwise lose their no Share of Cost Medi-Cal.
7N	Valid for Minor Consent services	No	Minor Consent Program. Covers eligible pregnant minors under the age of 21. Limited to services related to pregnancy and family planning. Paper Medi-Cal ID card issued.
8T	Restricted to pregnancy and emergency services	No	100 Percent Excess Property Child – Pregnancy and Emergency Services Only. Covers emergency and pregnancy-related services only to otherwise eligible children without satisfactory immigration status who are ages 6 to 19, or beyond 19 when inpatient status begins before the 19th birthday and family income is at or below 100 percent of the federal poverty level.

Please see **Dental Benefits**, page 6

**Dental Benefits** *(continued)*

**Emergency dental procedures are already available to individuals in the aid codes listed above.** For a list of the emergency dental procedures, see *Denti-Cal Bulletin* Vol. 21, No. 41, December 2005 ([www.denti-cal.ca.gov/provsrvcs/bulletins/Volume\\_21\\_Number\\_41.pdf](http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_21_Number_41.pdf)).

The procedures that have been added for pregnant women only are the following:

- 010 Examination, initial episode of treatment only
- 015 Evaluation, periodic
- 049 Prophylaxis, recipients younger than 12 years of age
- 050 Prophylaxis, recipients 13 years of age and older
- 062 Prophylaxis, including topical application of fluoride, recipients ages 6 through 17
- 452 Subgingival curettage and root planing per treatment
- 453 Occlusal adjustment (limited) per quadrant (minor spot grinding)
- 472 Gingivectomy or gingivoplasty per quadrant
- 473 Osseus and mucogingival surgery per quadrant
- 474 Gingivectomy, or gingivoplasty, treatment per tooth (fewer than six teeth)

If the recipient/patient has questions regarding Denti-Cal, please refer her to the Denti-Cal Beneficiary Toll-Free Line: (800) 322-6384.

**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).*

## 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
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).*

## 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.

### FEDERAL POVERTY INCOME GUIDELINES

200 Percent of Poverty by Family Size

<b>Number of Persons</b>	<b>Gross Monthly Income</b>	<b>Gross Annual Income</b>
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.

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.

*Please see Update Session, page 9*

## Update Session *(continued)*

### **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.*

### **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).*

### **Medi-Cal List of Contract Drugs**

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs*, *Drugs: Contract Drugs List Part 2 – Over-the-Counter Drugs* and *Drugs: Contract Drugs List Part 4 – Therapeutic Classifications Drugs*.

#### **Changes, effective April 1, 2007**

<b><u>Drug</u></b>	<b><u>Size and/or Strength</u></b>
* LEVONORGESTREL Tablets	0.75 mg
* Restricted to a maximum quantity of two tablets per dispensing with a maximum of six dispensings in any 12-month period for females <del>18 years of age and older</del> .	

*Please see **Contract Drugs**, page 10*

Changes, effective April 1, 2007 (continued)

<u>Drug</u>	<u>Size and/or Strength</u>
MORPHINE SULFATE	
Injection	
* Capsules, extended release	30 mg 60 mg 90 mg 120 mg
* Restricted to a maximum of 90 capsules per dispensing and a maximum of three dispensings of any strength in a 75-day period for claims submitted with dates of service from December 1, 2003, through September 30, 2005.	
* Capsules, sustained release	20 mg 30 mg 50 mg 60 mg 100 mg
* Restricted to a maximum of 90 capsules per dispensing and a maximum of three dispensings of any strength in a 75-day period. Exceptions to this restriction require prior authorization. (NDC labeler code 63857 [Faulding Laboratories or Alpha Pharma Branded Products Division, Inc.]	
* Tablets, <u>oral</u>	10 mg 15 mg 30 mg
* Restricted to a maximum of 90 tablets per dispensing and a maximum of three dispensings of any strength in a 75-day period. Exceptions to this restriction require prior authorization.	
* Tablets, long-acting	15 mg 30 mg 60 mg 100 mg
* Restricted to: 1) claims submitted with dates of service through November 30, 2003; or, 2) a maximum of 90 capsules per dispensing and a maximum of three dispensings of any strength in a 75-day period for claims submitted with dates of service from December 1, 2003, through September 30, 2005	
Liquid	10 mg/5 cc 20 mg/5 cc 20 mg/cc
* VALACYCLOVIR HCL	
Tablets	500 mg 1 Gm
* Restricted to use in herpes genitalis and herpes zoster (shingles). <b>(NDC labeler code 00173 [GlaxoSmithKline] only)</b>	

Please see Contract Drugs, page 11

**Contract Drugs** *(continued)*

**Change, effective July 1, 2007**

<u>Drug</u>	<u>Size and/or Strength</u>
MIRTAZAPINE	
Tablets or orally disintegrating tablets	15 mg
	30 mg
	45 mg
<del>(NDC labeler code 00052 [Organon, Inc.] for orally disintegrating tablets only.)</del>	



**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).



# New CMS-1500 Sample and Instructions

## Medi-Cal Required Fields

<div style="border: 1px solid black; border-radius: 5px; padding: 2px; display: inline-block;">1500</div>																									
<b>HEALTH INSURANCE CLAIM FORM</b> <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>																									
<small>PICA</small> <input type="checkbox"/>										<small>PICA</small> <input type="checkbox"/> <input type="checkbox"/>															
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN)</small>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>MEDI-CAL ID NUMBER</b>															
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>PATIENT'S COMPLETE NAME</b>						3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> SEX <input type="checkbox"/>			4. INSURED'S NAME (Last Name, First Name, Middle Initial) <b>MOTHER'S NAME FOR NEWBORN</b>																
5. PATIENT'S ADDRESS (No., Street) <b>PATIENT'S COMPLETE ADDRESS</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>			7. INSURED'S ADDRESS (No., Street)																
CITY <b>PATIENT'S CITY</b>			STATE <b>ST</b>			CITY			STATE																
ZIP CODE <b>PATIENT'S ZIP</b>			TELEPHONE (Include Area Code) <b>(PATIENT'S PHONE</b>			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) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX <input type="checkbox"/>																
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> SEX <input type="checkbox"/>						b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)			b. EMPLOYER'S NAME OR SCHOOL NAME																
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME <b>MEDICARE CARRIER CODE</b>																
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9-a-d</i> <b>OTHER COVERAGE/AMOUNT</b>																
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>																									
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 <b>NA</b> DATE <b>NA</b>						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 (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) <b>ONSET DATE</b>				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM <b>NA</b> TO <b>NA</b>																	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE <b>NAME OF REFERRING PROVIDER</b>						17a. NPI		17b. NPI		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM <b>FROM DOS</b> TO <b>THRU DOS</b>															
19. RESERVED FOR LOCAL USE <b>ADDITIONAL JUSTIFICATION PLACED HERE</b>						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		22. MEDICAID RESUBMISSION CODE <b>RESUBMIT CODE</b> ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER <b>TAR CONTROL NUMBER</b>															
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>PRIMARY ICD-9 CODE</b> 3. <b>NA</b> 2. <b>SECONDARY ICD-9 CODE</b> 4. <b>NA</b>						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) OPT/HCP/PCS MODIFIER		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EP307 Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
<b>DELAY</b>												<b>NON-NPI NUMBER</b>													
1	<b>DATE OF SERVICE FROM</b>		<b>DATE OF SERVICE THRU</b>		<b>POS</b>	<b>EMERG</b>	<b>PROC CODE</b>		<b>MODIFIERS</b>		<b>SERVICE CHARGES</b>		<b>Q</b>	<b>F</b>	<b>NPI</b>	<b>NPI</b>									
2																									
3																									
4																									
5																									
6																									
25. FEDERAL TAX I.D. NUMBER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				26. PATIENT'S ACCOUNT NO. <b>PATIENT ACCOUNT NUMBER</b>		27. ACCEPT ASSIGNMENT? (If opt. status, see 1500) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ <b>TOTAL CHARGES</b>		29. AMOUNT PAID \$ <b>TOTAL DEDUCTIONS</b>		30. BALANCE DUE \$ <b>NET BILLED</b>													
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.) <b>SIGNATURE OF PROVIDER OR PERSON AUTHORIZED</b> SIGNED _____ DATE _____						32. SERVICE FACILITY LOCATION INFORMATION <b>NAME AND ADDRESS OF SERVICE FACILITY</b> a. <b>FACILITY NPI</b> b. <b>NON-NPI NUMBER</b>						33. BILLING PROVIDER INFO & PH # <b>(PHONE NUMBER)</b> <b>BILLER ADDRESS</b> a. <b>BILLER NPI</b> b. <b>NON-NPI NUMBER</b>													
NUCC Instruction Manual available at: <a href="http://www.nucc.org">www.nucc.org</a>												APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)													

## Explanation of Form Items

The following item numbers and descriptions correspond to the sample *CMS-1500* on the previous page and are unique to Medi-Cal. All items must be completed unless otherwise noted in these instructions.

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

**UNDESIGNATED WHITE SPACE.** Do not type in the top one inch of the *CMS-1500* claim form, because this area is reserved for fiscal intermediary use.

<u>Item</u>	<u>Description</u>
-------------	--------------------

- |    |   |
|----|---|
| 1. | <b>MEDICAID/MEDICARE/OTHER ID.</b> If the claim is a Medi-Cal claim, enter an “X” in the Medicaid box. If submitting a Medicare/Medi-Cal crossover claim, use a copy of the original <i>CMS-1500</i> billed to Medicare and enter an “X” in both the <i>Medicaid</i> and <i>Medicare</i> boxes. |
|----|---|

**Note:** For more information about crossover claims, refer to the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in the appropriate Part 2 manual.

- |     |  |
|-----|--|
| 1A. | <b>INSURED’S ID NUMBER.</b> Enter the recipient identification number as it appears on the plastic Benefits Identification Card (BIC) or paper Medi-Cal ID card. |
|-----|--|

Newborn Infant

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 2 on a following page.)

- |    |  |
|----|--|
| 2. | <b>PATIENT’S NAME.</b> Enter the recipient’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 2. 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 also must be designated by a number or letter (example: Jones Baby Girl Twin A). Providers may also wish to use the *Patient’s Account No.* field (Box 26) to enter Twin A (or B). This is not a required field, and only for provider convenience. This field is repeated in all payment information (such as the *Remittance Advice Details* [RAD]), so when payment is received, the provider knows which claim was processed. The field allows 10 characters.

Enter the infant’s sex and date of birth in Box 3, and check the *Child* box in Box 6 (*Patient’s Relationship to Insured*). Enter the mother’s name in Box 4 (*Insured’s Name*).

Services rendered to an infant may be billed with the mother’s ID for the month of birth and the following month only. After this time, the infant must have his or her own Medi-Cal ID number.

To facilitate reimbursement for infants (including twins) using the mother’s ID number, enter NEWBORN INFANT USING MOTHER’S ID in the *Reserved for Local Use* field (Box 19) or NEWBORN INFANT USING MOTHER’S ID (TWIN A) or (TWIN B).

<u>Item</u>	<u>Description</u>
3.	<p><b>PATIENT'S BIRTH DATE/SEX.</b> Enter the recipient's date of birth in six-digit MMDDYY (Month, Day, Year) format (for example, September 1, 1963 = 090163). If the recipient's full date of birth is not available, enter the year preceded by 0101. (For newborns, see Item 2.)</p> <p>If the recipient is 100 years or older, enter the recipient's age and the full <u>four</u>-digit year of birth in the <i>Reserved for Local Use</i> field (Box 19).</p> <p>Enter an "X" in the "M" or "F" box. Obtain the sex indicator from the BIC. (For newborns, see Item 2.)</p>
4.	<p><b>INSURED'S NAME.</b> Not required by Medi-Cal, except when billing for an infant using the mother's ID. Enter the mother's name in this field when billing for the infant.</p>
5.	<p><b>PATIENT'S ADDRESS/TELEPHONE.</b> Enter recipient's complete address and telephone number.</p>
6.	<p><b>PATIENT RELATIONSHIP TO INSURED.</b> Not required by Medi-Cal. This field may be used when billing for an infant using the mother's ID by checking the <i>Child</i> box.</p>
7.	<p><b>INSURED'S ADDRESS.</b> Not required by Medi-Cal.</p>
8.	<p><b>PATIENT STATUS.</b> Not required by Medi-Cal.</p>
9.	<p><b>OTHER INSURED'S NAME.</b> Not required by Medi-Cal.</p>
9A.	<p><b>OTHER INSURED'S POLICY OR GROUP NUMBER.</b> Not required by Medi-Cal.</p>
9B.	<p><b>OTHER INSURED'S DATE OF BIRTH.</b> Not required by Medi-Cal.</p>
9C.	<p><b>EMPLOYER'S NAME OR SCHOOL NAME.</b> Not required by Medi-Cal.</p>
9D.	<p><b>INSURANCE PLAN NAME OR PROGRAM NAME.</b> Not required by Medi-Cal.</p>
10.	<p><b>IS PATIENT'S CONDITION RELATED TO</b></p>
10A.	<p><b>EMPLOYMENT.</b> Complete this field if services were related to an accident or injury. Enter an "X" in the <i>Yes</i> box if accident/injury is employment related. Enter an "X" in the <i>No</i> box if accident/injury is not employment related. If either box is checked, the date of the accident must be entered in the <i>Date of Current Illness, Injury or Pregnancy</i> field (Box 14).</p>
10B.	<p><b>AUTO ACCIDENT/PLACE.</b> Not required by Medi-Cal.</p>
10C.	<p><b>OTHER ACCIDENT.</b> Not required by Medi-Cal.</p>

- | <u>Item</u> | <u>Description</u>   |
|-------------|--|
| 10D.        | <b>RESERVED FOR LOCAL USE (Share of Cost).</b> 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 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 SOC, refer to the <i>Share of Cost (SOC)</i> section in the Part 1 manual. Also refer to the <i>Share of Cost (SOC): CMS-1500</i> section or the <i>Share of Cost (SOC): 30-1 for Pharmacy</i> section in the appropriate Part 2 manual.   |
| 11.         | <b>INSURED'S POLICY GROUP OR FECA NUMBER.</b> Not required by Medi-Cal.  |
| 11A.        | <b>INSURED'S DATE OF BIRTH/SEX.</b> Not required by Medi-Cal.  |
| 11B.        | <b>EMPLOYER'S NAME OR SCHOOL NAME.</b> Not required by Medi-Cal.   |
| 11C.        | <b>INSURANCE PLAN NAME OR PROGRAM NAME.</b> For Medicare/Medi-Cal crossover claims. Enter the Medicare Carrier Code.   |
| 11D.        | <b>IS THERE ANOTHER HEALTH BENEFIT PLAN.</b> Enter an "X" in the Yes box if recipient has Other Health Coverage (OHC). OHC includes insurance carriers, Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) who provide any of the recipient's health care needs. Eligibility under Medicare or a Medi-Cal Managed Care Plan (MCP) is not considered Other Health Coverage.<br><br>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 <i>Other Health Coverage (OHC) Guidelines for Billing</i> section in the Part 1 manual.<br><br>If the Other Health Coverage has paid, enter the amount in the upper right side of this field as shown in the illustration on a following page. Do not enter a decimal point (.) or dollar sign (\$). |
| 12.         | <b>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE.</b> Not required by Medi-Cal.   |
| 13.         | <b>INSURED'S OR AUTHORIZED PERSON'S SIGNATURE.</b> Not required. However, providers may note the Eligibility Verification Confirmation (EVC) number in this box.   |
| 14.         | <b>DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP).</b> Enter the date of onset of the recipient's illness, the date of accident/injury or the date of the last menstrual period (LMP).   |

- | <u>Item</u> | <u>Description</u>   |
|-------------|--|
| 15.         | <b>IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE.</b> Not required by Medi-Cal.  |
| 16.         | <b>DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION.</b> Not required by Medi-Cal.   |
| 17.         | <b>NAME OF REFERRING PROVIDER OR OTHER SOURCE.</b> 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 non-physician medical practitioner must be entered. |
| 17A.        | <b>UNLABELED.</b> Not required by Medi-Cal.  |
| 17B.        | <b>NPI.</b> Enter the National Provider Identifier (NPI).  |

Boxes 17 and 17B must be completed by the following providers:

- Clinical laboratory (services billed by laboratory)
- Durable Medical Equipment (DME) and medical supply
- Hearing aid dispenser
- Orthotist
- Prosthetist
- Nurse anesthetist
- Occupational therapist
- Physical therapist
- Podiatrist (when services are rendered in a Skilled Nursing Facility [NF] Level A or B)
- Portable X-ray
- Radiologist
- Speech pathologist
- Audiologist
- Pharmacies

In-State Referring Provider

A Universal Provider Information Number (UPIN) is not allowed.

Out-of-State Referring Provider

Claims must include a referring provider number using the referring provider's individual (not group) number. A license number or UPIN is not allowed.

Dental Referring Providers: In-State

Claims must include a referring provider number. Add the prefix "DDS" to the referring provider license number on the claim. A provider number or UPIN is not allowed.

Dental Referring Providers: Out-of-State

Claims must include a referring provider number. Add the prefix "DEN" to the referring provider license number on the claim. UPINs are not allowed.

Item    Description

Boxes 17 and 17B (*continued*)

A non-physician medical practitioner authorized to refer with the physician's provider number should include the number of the supervising physician on the referral. The billing provider also should enter the number of the supervising physician. Claims with a non-physician medical practitioner number will not be reimbursed.

When a billing provider receives a *Resubmission Turnaround Document* (RTD) or denial due to an invalid referring provider number, the referring provider should be contacted to verify the status of the provider number.

A physician's assistant (and other non-physician practitioners authorized to refer with the physician's number) should include the provider number of the supervising physician on the referral. The billing provider should enter the provider number of the supervising physician. Claims with a Non-physician Medical Practitioner (NMP) license number will not be reimbursed.

**Note:** Referring providers who would like to participate in the Medi-Cal program may contact the EDS Telephone Service Center (TSC) at 1-800-541-5555.

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.
19.    **RESERVED FOR LOCAL USE.** Use this area for procedures that require additional information or justification. For specific "By Report" attachment requirements, refer to the *CMS-1500 Special Billing Instructions* section of this manual.

Attachments

Claims for "By Report" codes, complicated procedures (modifier 22), unlisted services and anesthesia time require attachments. This information may also be entered in the *Reserved for Local Use* field (Box 19) if space permits.

Reports are not required for routine procedures. Non-reimbursable CPT-4 codes are listed in the *TAR and Non-Benefit List: Codes 10000 – 99999* sections of the appropriate Part 2 manual. Refer to "Attachments" in the *CMS-1500 Special Billing Instructions* section in this manual, the CPT-4 book or in the appropriate policy sections for details.

**Note:** Please do not staple attachments.

Item      Description

20.      **OUTSIDE LAB?** If this claim includes charges for laboratory work performed by a licensed laboratory, enter an "X". "Outside" laboratory refers to a laboratory not affiliated with the billing provider. State in Box 19 that a specimen was sent to an unaffiliated laboratory. Leave blank if not applicable.

**OUTSIDE LAB \$ CHARGES.** Not required by Medi-Cal.

21.1      **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.** 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 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 and materials (includes DME [except incontinence supplies]), hearing aids, orthotic and prosthetic appliances
4. Medical transportation
5. Pathology services (referenced in the CPT-4 book)
6. Radiology services (except: CAT scan, nuclear medicine, ultrasound, radiation therapy, and portable X-ray services, which require diagnosis codes).

21.2      **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.** 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 decimal point.)

**Note:** Medi-Cal only accepts two diagnosis codes. Codes entered in Box 21.3 and 21.4 will not be used for claims processing.

**Note to Incontinence Supply Providers:** Only the following ICD-9-CM codes will be accepted as the secondary diagnosis.

ICD-9-CM Code	
<hr/>	
307.6	788.34
307.7	788.35
787.6	788.36
788.30	788.37
788.31	788.38
788.32	788.39
788.33	

21.3      **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.** Not required by Medi-Cal.

21.4      **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY.** Not required by Medi-Cal.

Item      Description

22.      **MEDICAID RESUBMISSION CODE/ORIGINAL REF. NO.**  
Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional. The Medicare status codes are:

<u>Code</u>	<u>Explanation</u>
0	Under 65, does not have Medicare coverage
1 *	Benefits exhausted
2 *	Utilization committee denial or physician non-certification
3 *	No prior hospital stay
4 *	Facility denial
5 *	Non-eligible provider
6 *	Non-eligible recipient
7 *	Medicare benefits denied or cut short by Medicare intermediary
8 *	Non-covered services
9 *	PSRO denial
L *	Medi/Medi Charpentier: Benefit Limitations
R *	Medi/Medi Charpentier: Rates
T *	Medi/Medi Charpentier: Both Rates and Benefit Limitations

\* Documentation required. Refer to the *Medicare/Medi-Cal Crossover Claims: CMS-1500* section in the appropriate Part 2 manual for additional information.

23.      **PRIOR AUTHORIZATION NUMBER.** For physician and podiatry 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. Refer to the *CMS-1500 Special Billing Instructions* section in this manual for more information.

24.1      **CLAIM LINE.** Information for completing a claim line follows in Items 24A – 24J. Refer to the *CMS-1500 Special Billing Instructions* section in this manual for more information.

**Note:** Do not enter data in the shaded area except for 24C.

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; for example, June 24, 2007 = 062407. Refer to the *CMS-1500 Special Billing Instructions* section in this manual for more information.

Item    Description

24B.    **PLACE OF SERVICE.** Enter one code from the list below indicating where the service was rendered:

<u>Code</u>	<u>Place of Service</u>
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgery Clinic
25	Birth Center
31	Skilled Nursing Facility (SNF)
32	Nursing Facility (NF)
41	Ambulance (Land)
42	Ambulance (Air or Water)
53	Community Mental Health Center
54	Intermediate Care Facility – Mentally Retarded
55	Residential Substance Abuse Treatment Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	State or Local Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other (if subacute care, use modifier HB to indicate adult or modifier HA to indicate child)

24C.    **EMG.** Emergency or delay reason codes.

**Delay Reason Code:** If there is no emergency indicator in Box 24C, and only a delay reason code is placed in this box, enter it in the unshaded, bottom portion of the box. If there is an emergency indicator, enter the delay reason in the top shaded portion of this box. Include the required documentation. 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. (Refer to the *CMS-1500 Submission and Timeliness Instructions* section in this manual.)

Item    Description  
24C.    **EMG (continued).**

**Emergency Code:** Only one emergency indicator is allowed per claim, and must be placed in the bottom unshaded portion of Box 24C. 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, dentist, or pharmacist'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.

24D.    **PROCEDURES, SERVICES OR SUPPLIES/MODIFIER.** Enter the applicable procedure code (HCPCS or CPT-4) and modifier(s). Note that the descriptor for the code must match the procedure performed and that the modifier(s) must be billed appropriately. Medi-Cal accepts up to four modifiers for a procedure on a single claim line. Enter modifiers in the boxes provided.

Medical Supply Codes

If the item being billed is a medical supply, use the manufacturer code found in the *Medical Supplies: Manufacturer Billing Codes* section and the product code found in the Medical Supplies List section of the Part 2 Durable Medical Equipment (DME) and Medical Supplies or Pharmacy manual.

When billing on a *CMS-1500* claim form, enter the two-digit manufacturer code after the five-digit medical supply code. For example, if the manufacturer billing code for medical supply code 9917B is "OT", then enter the code as "9917BOT". Enter the code right-justified.

Medicare/Medi-Cal Recipients

Medicare non-covered services codes are listed in the Medicare non-covered services codes sections in this manual. Only those services listed in the Medicare non-covered sections may be billed directly to Medi-Cal. All others must be billed to Medicare first.

For a listing of approved CPT-4 and Medi-Cal-only modifier codes, refer to the *Modifiers: Approved List* section in the appropriate Part 2 manual.

To determine if the medical supply must be billed to Medicare prior to billing Medi-Cal, refer to the *Medical Supplies: Medicare Covered Services* section in the appropriate Part 2 manual. Those medical supplies listed in *Medical Supplies: Medicare Covered Services* section must be billed to Medicare prior to billing Medi-Cal.

24E.    **DIAGNOSIS POINTER.** As required by Medi-Cal.

Item    Description

24F.    **CHARGES.** In full dollar amount, enter the usual and customary fee for service(s). 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.

Laboratory Charges

When billing “outside” laboratory work, enter the actual amount charged by the laboratory in Box 24F. Handling charges must be billed as a separate line item.

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 of up to 999. Do not enter a decimal point (.). Therefore, a quantity of “1” entered anywhere in the field, or with leading zeroes, would be seen by the Medi-Cal system as “001” and a “10” entered anywhere in the field seen as “010.”

Billing for Time

Providers billing for units of time should enter the time in 15-minute increments (for example, for one hour, enter “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.

Code        Description

- |   |  |
|---|--|
| 1 | Family Planning/Sterilization (sterilization <i>Consent Form</i> must be attached to the claim if code 1 is entered) |
| 2 | Family Planning/Other  |
| 3 | CHDP Screening Related   |

Refer to the *Family Planning* section of the appropriate Part 2 manual for further details.

24I.    **ID QUALIFIER FOR RENDERING PROVIDER.** Not required by Medi-Cal.

24J.    **RENDERING PROVIDER ID NUMBER.** Enter the NPI for a rendering provider (unshaded area), if the provider is billing under a group NPI.

The rendering provider instructions apply to services rendered by the following providers:

- |                         |                          |
|-------------------------|--------------------------|
| Acupuncturists          | Physician groups         |
| Chiropractors           | Physicians               |
| Laboratories            | Podiatrists              |
| Licensed audiologists   | Portable X-ray providers |
| Occupational therapists | Prosthetists             |
| Ophthalmologists        | Psychologists            |
| Orthotists              | Radiology labs           |
| Physical therapists     | Speech pathologists      |

Deleting Information:  
Items 24A thru 24J

If an error has been made to specific billing information entered on Items 24A thru 24J, draw a line through the entire detail line using a blue or black ballpoint pen. Enter the correct billing information on another line.

**Note:** Do not “black-out” entire claim line. Deleted information may be used to determine previous payment.

24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	PHYSICIAN OR SUPPLIER INFORMATION
	From	To							(Explain Unusual Circumstances)								
	MM	DD	YY	MM	DD	YY		OPT/HCPOS									
1	<del>11</del>	<del>01</del>	<del>05</del>				<del>11</del>		<del>97810</del>	<del>A3</del>		<del>50.00</del>	<del>1</del>		<del>NPI</del>	<del>0123456789</del>	
2	<del>11</del>	<del>01</del>	<del>05</del>				<del>11</del>		<del>97810</del>	<del>A1</del>		<del>75.00</del>	<del>1</del>		<del>NPI</del>	<del>0123456789</del>	
3														NPI			
4														NPI			
5														NPI			
6														NPI			

Sample of Deleted Information.

- | <u>Item</u> | <u>Description</u>   |
|-------------|--|
| 24.2 – 24.6 | <b>ADDITIONAL CLAIM LINES.</b> Follow instructions for each claim line.  |
| 25.         | <b>FEDERAL TAX I.D. NUMBER.</b> Not required by Medi-Cal.  |
| 26.         | <b>PATIENT’S ACCOUNT NO.</b> This is an optional field that will help providers to easily identify a recipient on a <i>Resubmission Turnaround Document (RTD)</i> and <i>Remittance Advice Details (RAD)</i> . Enter the patient’s control number or account number in this field. A maximum of 10 numbers and/or letters may be used. Whatever is entered here will appear on the RTD and RAD. Refer to the <i>Resubmission Turnaround Document (RTD) Completion</i> and <i>Remittance Advice Details (RAD)</i> examples sections in this manual. |
| 27.         | <b>ACCEPT ASSIGNMENT?</b> Not required by Medi-Cal.  |
| 28.         | <b>TOTAL CHARGE.</b> In full dollar amount, enter the total for all services. 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).  |

- | <u>Item</u> | <u>Description</u>  |               |               |        |           |                    |               |  |             |        |
|-------------|---|---------------|---------------|--------|-----------|--------------------|---------------|--|-------------|--------|
| 29.         | <b>AMOUNT PAID.</b> Enter the amount of payment received from the Other Health Coverage (Box 11D) and patient's Share of Cost (Box 10D). 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). <u>Do not enter Medicare payments in this box.</u> The Medicare payment amount will be calculated from the Medicare <i>Explanation of Medicare Benefits</i> (EOMB)/ <i>Medicare Remittance Notice</i> (MRN)/ <i>Remittance Advice</i> (RA) when submitted with the claim.  |               |               |        |           |                    |               |  |             |        |
| 30.         | <b>BALANCE DUE.</b> Enter the difference between <i>Total Charges</i> and <i>Amount Paid</i> . Do not enter a decimal point (.) or dollar sign (\$). Enter full dollar amount and cents even if the amount is even (e.g., if billing for \$100, enter 10000 not 100).<br><br><table border="0" style="margin-left: 100px;"> <tr> <td></td> <td style="text-align: right;">Total Charges</td> <td style="text-align: right;">Box 28</td> </tr> <tr> <td>(minus) –</td> <td style="text-align: right;"><u>Amount Paid</u></td> <td style="text-align: right;"><u>Box 29</u></td> </tr> <tr> <td></td> <td style="text-align: right;">Balance Due</td> <td style="text-align: right;">Box 30</td> </tr> </table> |               | Total Charges | Box 28 | (minus) – | <u>Amount Paid</u> | <u>Box 29</u> |  | Balance Due | Box 30 |
|             | Total Charges   | Box 28        |               |        |           |                    |               |  |             |        |
| (minus) –   | <u>Amount Paid</u>  | <u>Box 29</u> |               |        |           |                    |               |  |             |        |
|             | Balance Due   | Box 30        |               |        |           |                    |               |  |             |        |
| 31.         | <b>SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS.</b> The claim must be signed and dated by the provider or a representative assigned by the provider. Use <u>black</u> ballpoint pen only.<br><br>An <u>original</u> signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable.   |               |               |        |           |                    |               |  |             |        |
| 32.         | <b>SERVICE FACILITY LOCATION INFORMATION.</b> Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. Enter the telephone number of the facility where services were rendered, if other than home or office.<br><br><b>Note:</b> Not required for clinical laboratories when billing for their own services.  |               |               |        |           |                    |               |  |             |        |
| 32A.        | Enter the NPI of the facility where the services were rendered.   |               |               |        |           |                    |               |  |             |        |
| 32B.        | Enter the Medi-Cal provider number for an atypical service facility.  |               |               |        |           |                    |               |  |             |        |
| 33.         | <b>BILLING PROVIDER INFO AND PHONE NUMBER.</b> Enter the provider name. Enter the provider address, without a comma between the city and state, and a nine-digit ZIP code, without a hyphen. Enter the telephone number.  |               |               |        |           |                    |               |  |             |        |
| 33A.        | Enter the billing provider's NPI.   |               |               |        |           |                    |               |  |             |        |

Item    Description

33B.    Used for atypical providers only. Enter the Medi-Cal provider number for the billing provider.

**Note:** 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.

Check Digits

For atypical providers, CDHS assigns a check digit to each provider to verify accurate input of the Medi-Cal provider number. The check digit is not a required item. However, including the check digit ensures that reimbursement for the claim is made to the correct provider. Providers should enter their check digit to the right of the Medi-Cal provider number in Box 32B. Providers who do not know their check digit should contact the EDS Telephone Service Center (TSC) at 1-800-541-5555.

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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