MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Allied Health • Orthotics and Prosthetics

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Contents

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.

DME Medicare/Medi-Cal Crossover Contractor Update

Effective October 1, 2006, Noridian Administrative Services (NAS) replaced CIGNA as a Medicare/Medi-Cal administrative contractor. Noridian's responsibility is to transmit Durable Medical Equipment (DME), prosthetic, orthotic and medical supply Medicare/Medi-Cal crossover claims to EDS. Noridian is referred to as a Durable Medical Equipment Medicare Administrative Contractor (DMAC). CIGNA was referred to as a DME Regional Carrier (DMERC).

Manual Updates

As a result of this change, references to CIGNA are being removed from the Medi-Cal provider manuals and replaced with "Noridian." In addition, references to DMERC are being changed to DMAC.

This information is reflected on manual replacement pages medicare 4 and 9 (Part 1) and medi cr cms exa 3 (Part 2). The medi cr cms exa 3 page will be included in the May 2007 Special Update.

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.

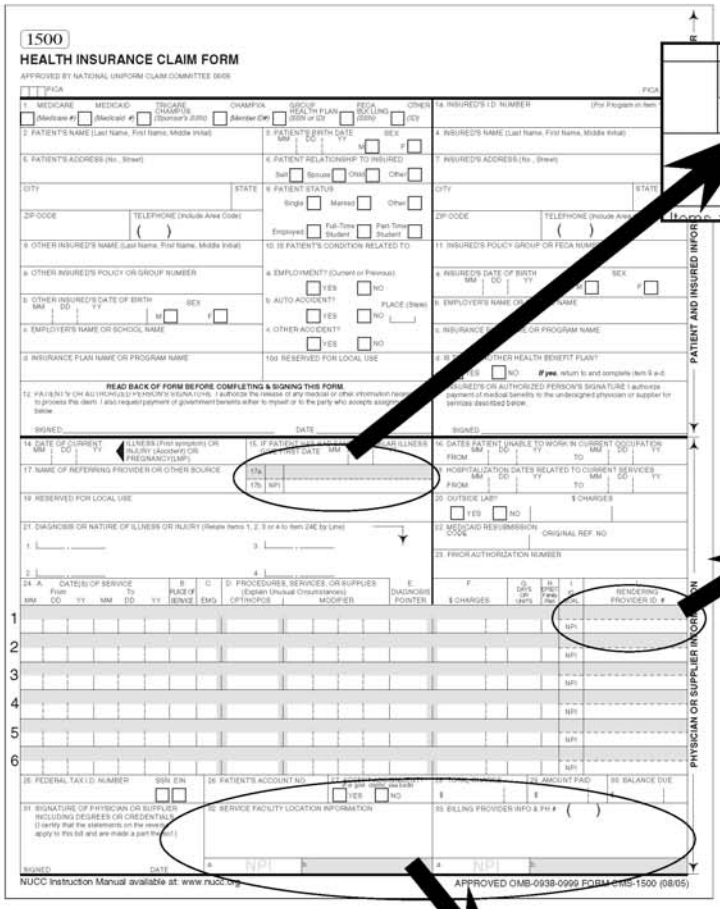
Reminder: SCG 02 includes all the codes in SCG 01; SCG 03 includes all the codes in SCG 01 and SCG 02; and SCG 07 includes all the codes in SCG 01. These same "rules" apply to end-dated codes.

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 *CMS-1500* 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.)



BOX 17

Enter the referring provider's Medi-Cal number in **Box 17A** and NPI in **Box 17B**.

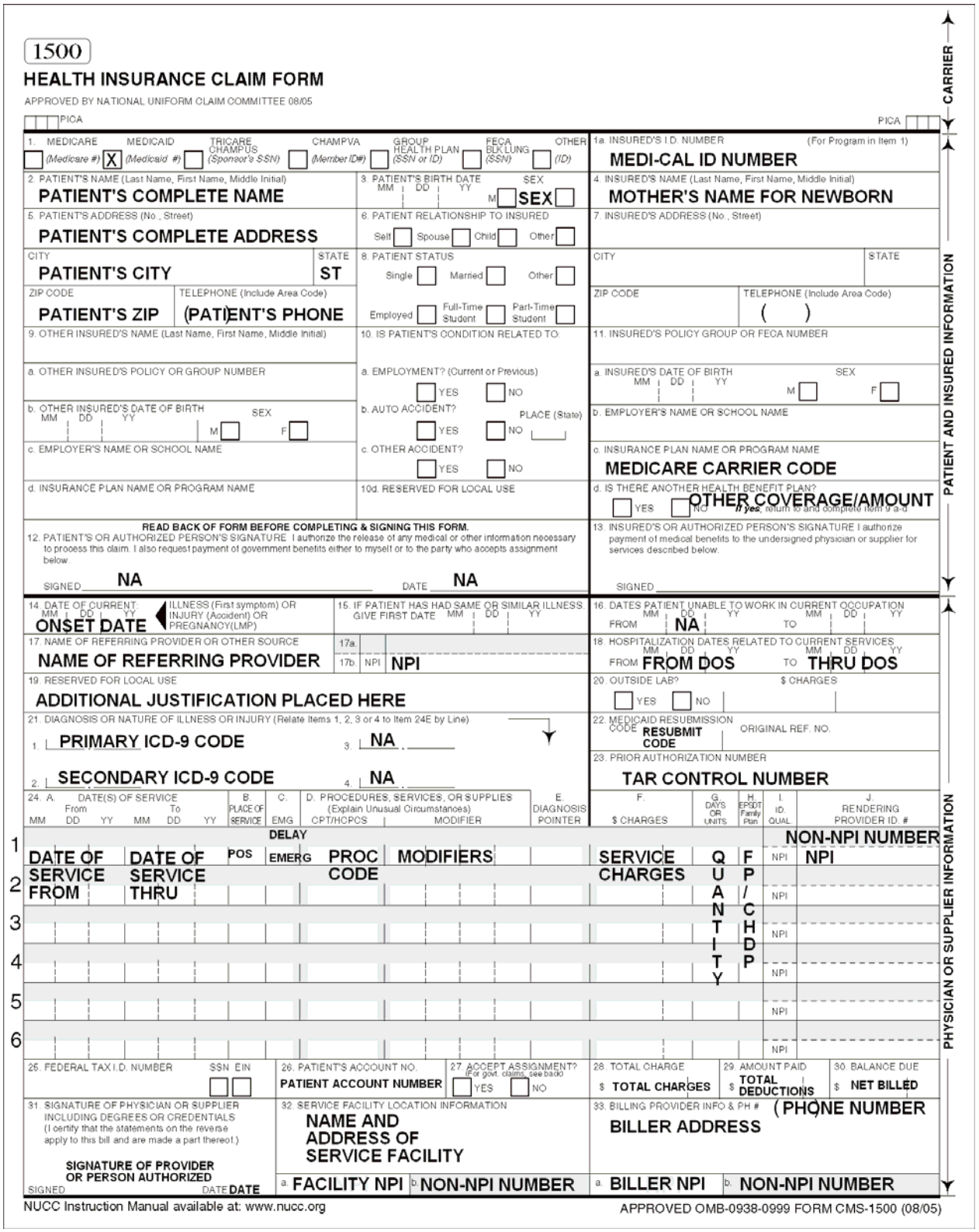
BOX 24J

When necessary, enter the rendering provider's Medi-Cal number in the shaded area of **Box 24J** and NPI in the unshaded area.

BOX 32: Enter the service facility's NPI in **Box 32A** and Medi-Cal number in **Box 32B**.

BOX 33: Enter the billing provider's NPI in **Box 33A** and Medi-Cal number in **Box 33B**.

New CMS-1500 Sample and Instructions
Medi-Cal Required Fields



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID X (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): MEDI-CAL ID NUMBER

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED: Self | Spouse | Child | Other

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

CITY: PATIENT'S CITY | STATE: ST

8. PATIENT STATUS: Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE: PATIENT'S ZIP | TELEPHONE (Include Area Code): (PATIENT'S PHONE

ZIP CODE | TELEPHONE (Include Area Code): ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES | NO

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

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M | F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: MEDICARE CARRIER CODE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO: OTHER COVERAGE/AMOUNT

If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED NA DATE NA

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: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): ONSET DATE

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY: FROM NA TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: NAME OF REFERRING PROVIDER

17a.

17b. NPI: NPI

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

19. RESERVED FOR LOCAL USE: ADDITIONAL JUSTIFICATION PLACED HERE

20. OUTSIDE LAB? YES | NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. PRIMARY ICD-9 CODE
2. SECONDARY ICD-9 CODE
3. NA
4. NA

22. MEDICAID RESUBMISSION CODE: RESUBMIT CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: TAR CONTROL NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	DELAY	POS	EMERG	PROC CODE	MODIFIERS		SERVICE CHARGES	QUANTITY	FP/CHDP	NPI	NON-NPI NUMBER NPI
2	DATE OF SERVICE FROM	DATE OF SERVICE THRU								NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.: PATIENT ACCOUNT NUMBER

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

28. TOTAL CHARGE: $ TOTAL CHARGES

29. AMOUNT PAID: $ TOTAL DEDUCTIONS

30. BALANCE DUE: $ NET BILLED

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.)

SIGNATURE OF PROVIDER OR PERSON AUTHORIZED

SIGNED DATE DATE

32. SERVICE FACILITY LOCATION INFORMATION: NAME AND ADDRESS OF SERVICE FACILITY

a. FACILITY NPI | b. NON-NPI NUMBER

33. BILLING PROVIDER INFO & PH #: BILLER ADDRESS (PHONE NUMBER

a. BILLER NPI | b. NON-NPI NUMBER

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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.

Item	Description

1. **MEDICAID/MEDICARE/OTHER ID.** 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 *CMS-1500* billed to Medicare and enter an "X" in both the *Medicaid* and *Medicare* 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. **INSURED'S ID NUMBER.** 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. **PATIENT'S NAME.** 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).

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

Item	Description
10D.	**RESERVED FOR LOCAL USE (Share of Cost).** 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 $100, enter 10000 not 100). For more information about SOC, refer to the *Share of Cost (SOC)* section in the Part 1 manual. Also refer to the *Share of Cost (SOC): CMS-1500* section or the *Share of Cost (SOC): 30-1 for Pharmacy* section in the appropriate Part 2 manual.
11.	**INSURED'S POLICY GROUP OR FECA NUMBER.** Not required by Medi-Cal.
11A.	**INSURED'S DATE OF BIRTH/SEX.** Not required by Medi-Cal.
11B.	**EMPLOYER'S NAME OR SCHOOL NAME.** Not required by Medi-Cal.
11C.	**INSURANCE PLAN NAME OR PROGRAM NAME.** For Medicare/Medi-Cal crossover claims. Enter the Medicare Carrier Code.
11D.	**IS THERE ANOTHER HEALTH BENEFIT PLAN.** Enter an "X" in the *Yes* box if recipient has Other Health Coverage (OHC). OHC includes insurance carriers, Prepaid Health Plans (PHPs) and Health Maintenance Organizations (HMOs) who provide any of the recipient's health care needs. Eligibility under Medicare or a Medi-Cal Managed Care Plan (MCP) is not considered Other Health Coverage. Medi-Cal policy requires that, with certain exceptions, providers must bill the recipient's other health insurance coverage prior to billing Medi-Cal. For details about OHC, refer to the *Other Health Coverage (OHC) Guidelines for Billing* section in the Part 1 manual. If the Other Health Coverage has paid, enter the amount in the upper right side of this field as shown in the illustration on a following page. Do not enter a decimal point (.) or dollar sign ($).
12.	**PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE.** Not required by Medi-Cal.
13.	**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE.** Not required. However, providers may note the Eligibility Verification Confirmation (EVC) number in this box.
14.	**DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY (LMP).** Enter the date of onset of the recipient's illness, the date of accident/injury or the date of the last menstrual period (LMP).

Item Description

15. **IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE.** Not required by Medi-Cal.

16. **DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION.** Not required by Medi-Cal.

17. **NAME OF REFERRING PROVIDER OR OTHER SOURCE.** 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. **UNLABELED.** Not required by Medi-Cal.

17B. **NPI.** 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	
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:

Code	Explanation
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:

Code	Place of Service
11	Office
12	Home
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room (Hospital)
24	Ambulatory Surgery Clinic
25	Birthing 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 *Consent Form* 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.

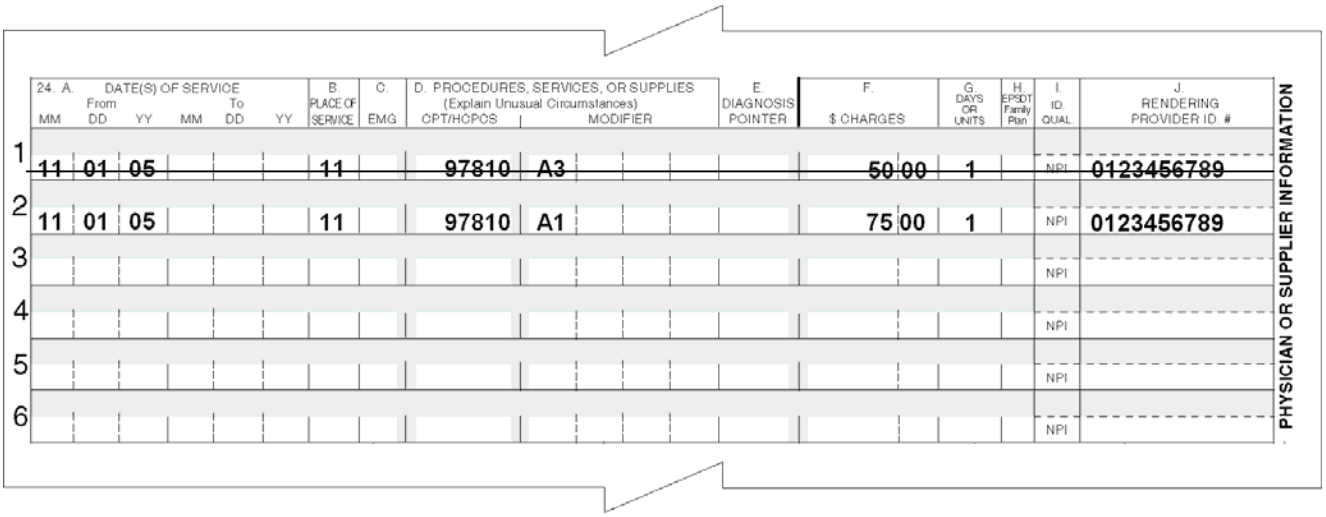
The rendering provider instructions apply to services rendered by the following providers:

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 From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	11	01	05				11		97810	A3		50 00	1		NPI	0123456789
2	11	01	05				11		97810	A1		75 00	1		NPI	0123456789
3															NPI	
4															NPI	
5															NPI	
6															NPI	

PHYSICIAN OR SUPPLIER INFORMATION

Sample of Deleted Information.

Item	Description
24.2 – 24.6	**ADDITIONAL CLAIM LINES.** Follow instructions for each claim line.
25.	**FEDERAL TAX I.D. NUMBER.** Not required by Medi-Cal.
26.	**PATIENT'S ACCOUNT NO.** This is an optional field that will help providers to easily identify a recipient on a *Resubmission Turnaround Document* (RTD) and *Remittance Advice Details* (RAD). 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 *Resubmission Turnaround Document* (RTD) *Completion* and *Remittance Advice Details* (RAD) examples sections in this manual.
27.	**ACCEPT ASSIGNMENT?** Not required by Medi-Cal.
28.	**TOTAL CHARGE.** 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).

Item Description

29. **AMOUNT PAID.** 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). Do not enter Medicare payments in this box. The Medicare payment amount will be calculated from the Medicare *Explanation of Medicare Benefits* (EOMB)/*Medicare Remittance Notice* (MRN)/*Remittance Advice* (RA) when submitted with the claim.

30. **BALANCE DUE.** Enter the difference between *Total Charges* and *Amount Paid*. 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).

		Total Charges	Box 28
(minus)	–	Amount Paid	Box 29
		Balance Due	Box 30

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS.** The claim must be signed and dated by the provider or a representative assigned by the provider. Use black ballpoint pen only.

An original signature is required on all paper claims. The signature must be written, not printed. Stamps, initials or facsimiles are not acceptable.

32. **SERVICE FACILITY LOCATION INFORMATION.** 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.

Note: 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. **BILLING PROVIDER INFO AND PHONE NUMBER.** 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.

Instructions for Manual Replacement Pages — Part 2

April 2007

Orthotics and Prosthetics Bulletin 378

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:	dura cd 21/22 *

* Pages updated due to ongoing provider manual revisions.