CRISS

CHILDREN'S REGIONAL INTEGRATED SERVICE SYSTEM

CCS CRISS Claims Toolkit Webinar

October 22, 2024

California Children's Services Overview

What is California Children's Services?

Established in 1927, CCS is the oldest public health program in California.

Authorizes diagnostic and treatment services for children who are medically, and residentially eligible for CCS. Financial eligibility is also required for treatment services outside the MTP.

Not an insurance company

Designed and operated as state/county partnership, with oversight and policy direction from the Department of Health Care Services

CCS is a Public Health Program

- Establishes an "architecture of care" for the regionalized pediatric subspecialty healthcare system, including multidisciplinary Special Care Centers and Hospitals
- Establishes and enforces quality standards
- Assures the provision of health care that might otherwise be unavailable to low-income children with serious, chronic, and/or disabling illness

CCS Promotes Health Equity

- By assuring the provision of high-quality healthcare and related services for low-income children
- By providing multi-disciplinary, family-centered care coordination and case management
- By promoting linkages to culturally appropriate providers
- By assisting families to navigate the complex health care system and training parents and clients in self-advocacy
- By providing access to out-of-state services when medically necessary

CCS Health Care Delivery Models

Independent	Larger counties manage the CCS program through their county Public Health departments. County CCS staff determine eligibility.
Dependent	Smaller counties share program management with the Integrated Systems of Care Division (ISCD) at State DHCS.
Whole Child Model	County CCS or ISCD determines program eligibility. Medi-Cal Managed Care Plan provides case management and pays claims for all medically necessary services for children enrolled in the health plan.
Classic	Fee-for-service model; carved out of Managed Care Plan. County CCS or ISDCD provides medical case management and authorizes services related to the CCS-eligible condition, and the Medi-Cal Fiscal Intermediary pays claims.

Eligibility

- Age: Children/youth from birth to 21st birthday
- Residential: must be a permanent resident of the California County where the family applies
- Medical: CCS covers medical conditions as described in regulation. Generally, these are serious, complex, chronic, life-limiting and/or physically disabling conditions that require medical, surgical, or rehabilitative services. Medical eligibility is determined at the county or state level by physician review.
- Financial (only for treatment services outside the MTP):
  - If the child is not already enrolled in Full-Scope Medi-Cal, then one of the following must apply:
    - the family's Adjusted Gross Income (AGI) must be less than $40,000 per year; or
    - anticipated out-of-pocket costs for treating the CCS condition must exceed 20% of the family's AGI
  - There is no financial requirement for diagnostic authorizations, High Risk Infant Follow-Up (HRIF), or Medical Therapy Program

Children's Regional Integrated Service System (CRISS)

Children's Regional Integrated Service System (CRISS)

- Established in 1996 to create a regional seamless system of care for the CCS children in the 32-county region in Northern California.
- CRISS brings together the three major CCS stakeholder groups in a cohesive regional coalition for collaboration and planning
- These stakeholder groups are the:
  - CCS county programs
  - Providers: Children's hospitals and pediatric provider organizations
  - Family support organizations

Goals of CRISS

- Maintain a consistent regional vehicle for coordination and collaboration in the CRISS region.
- Promote family-centered care and medical homes for children with special health care needs.
- Improve cross-county consistency in eligibility determinations, authorizations, policy interpretations, and other administrative processes.
- Improve regional information sharing with members and other groups regarding the CCS program, best practices, and quality standards.

CRISS Work Groups

- Five Work Groups focus on activities of CRISS:
  - **Medical Eligibility Work Group:** Reviews CCS medical eligibility regulations and their local interpretation on a regular basis, recommends clarifications and updates to the state, and agrees on consistent interpretation and implementation in our region
  - **Medical Therapy Program Work Group:** Addresses Durable Medical Equipment (DME) and medical therapy issues
  - **Family Centered Care Work Group:** Promotes family-centered care for children with special health care needs and provides technical assistance to support local CCS program efforts towards family centeredness
  - **Claims Work Group:** Addresses difficulties with CCS claims payment, discrepancies in billing, and family issues regarding billing
  - **Whole Child Model Work Group:** Monitors WCM implementation and makes recommendations to improve services to CCS children enrolled in WCM plans

How to Use the Toolkit

An overview of what is included and what has been added since the previous edition

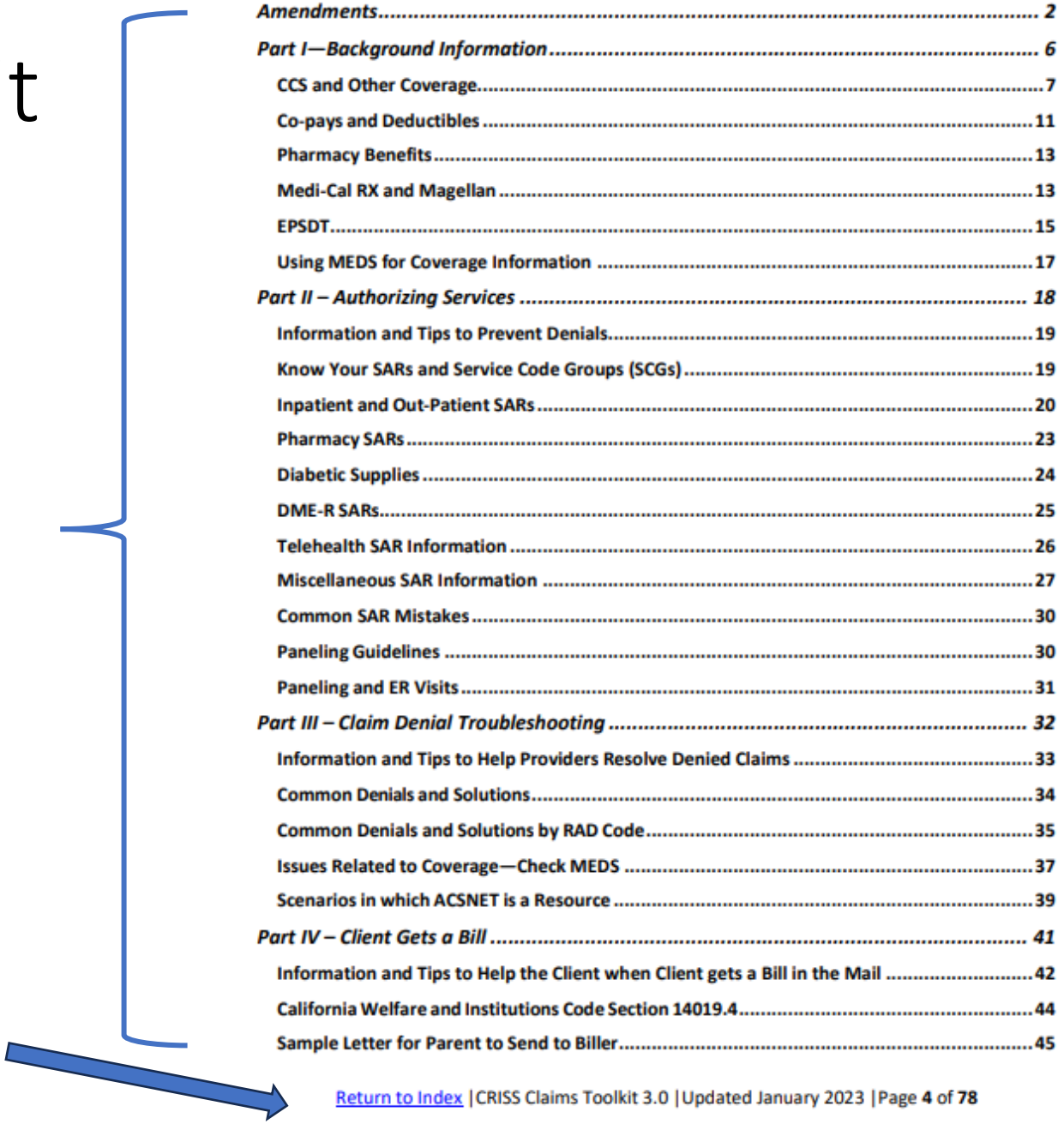
Disclaimer

- The information in this toolkit is related to issuing authorizations and resolving claims specific to CCS eligible children who are active in a:
  - Classic CCS county, or
  - WCM county but not enrolled in the Medi-Cal Managed Care Plan.

- The tips and information have been collected by CCS staff to help providers resolve billing issues. It should not be considered an official manual. The Medi-Cal Fiscal Intermediary is the authority to whom providers should be referred.

Navigating the Toolkit

- Index hyperlinks
- Return to Index



Contents

Amendments *2*
Part I—Background Information *6*
CCS and Other Coverage 7
Co-pays and Deductibles 11
Pharmacy Benefits 13
Medi-Cal RX and Magellan 13
EPSDT 15
Using MEDS for Coverage Information 17
Part II – Authorizing Services *18*
Information and Tips to Prevent Denials 19
Know Your SARs and Service Code Groups (SCGs) 19
Inpatient and Out-Patient SARs 20
Pharmacy SARs 23
Diabetic Supplies 24
DME-R SARs 25
Telehealth SAR Information 26
Miscellaneous SAR Information 27
Common SAR Mistakes 30
Paneling Guidelines 30
Paneling and ER Visits 31
Part III – Claim Denial Troubleshooting *32*
Information and Tips to Help Providers Resolve Denied Claims 33
Common Denials and Solutions 34
Common Denials and Solutions by RAD Code 35
Issues Related to Coverage—Check MEDS 37
Scenarios in which ACSNET is a Resource 39
Part IV – Client Gets a Bill *41*
Information and Tips to Help the Client when Client gets a Bill in the Mail 42
California Welfare and Institutions Code Section 14019.4 44
Sample Letter for Parent to Send to Biller 45

Part I – Background Information

Understanding how CCS fits into California's Medi-Cal Payment System, and who the payors are

New in this edition!

- CCS and Other Coverage
- Co-pays and Deductibles

CCS coverage types	Refer to the CRISS Guide to CCS Aid Codes for more details **CCS with full-scope, no share-of-cost Medi-Cal**--financial and residential eligibility is automatic based on Medi-Cal eligibility. • **9N**—without a Program Services Agreement (PSA) • **9K**—with a Program Services Agreement (PSA) **CCS with OTLICP**—financial and residential eligibility is automatic based on Medi-Cal eligibility. • **9U**—OTLICP with income less than $40,000/year or unknown income • **9R**—OTLICP with income over $40,000/year **Straight-CCS or CCS-only (9K)**--a child who meets financial, residential and medical eligibility but is not eligible for Medi-Cal and therefore is not enrolled in a Medi-Cal Managed Care Plan. **MTP-only (9M)**--open for Medical Therapy Services only, not eligible for the CCS administrative services (treatment/DME).

Pharmacy Benefits Medi-Cal RX and Prime Therapeutics	
Prime Therapeutics/Medi-Cal Rx (formerly known as Magellan)	As of 1/1/2022, Medi-Cal transitioned all pharmacy services from Managed Care to Fee-for-service. This new pharmacy benefit model is called Medi-Cal Rx. It is a single delivery system managed by Prime Therapeutics Medicaid Administration, Inc. Prime Therapeutics will handle all claims administration, processing and payment. This means that drugs and pharmacy services normally authorized by CCS will be authorized by Prime Therapeutics.
What medications are covered by Prime Therapeutics and what is covered by CCS	Medi-Cal Rx applies to all services deemed as 'pharmacy' and includes Out-Patient drugs (prescription and over the counter), enteral nutrition products and some medical supplies. Includes all services traditionally billed on a Pharmacy Claim Form. Claims that would pay using a CMS 1500 are still within the scope of CCS responsibility. If the item is claimed by NDC = Medi-Cal Rx, provider submits claim to Prime Therapeutics If the item is claimed by a HCPC = issue a SAR, and provider will submit claim to the Medi-Cal FI just as before Medi-Cal Rx.
Medical RX Bulletins and News	This is a good place to search for news on specific pharmacy issues. You can also sign up for the subscription service so that you get an email anytime there is an update to a process in Medi-Cal Rx.
CCS and Medi-Cal Rx FAQs prior to implementation	Medi-Cal Rx FAQs.pdf
Contract Drug List	The Contract Drug List (CDL) is a list of drugs that are on the Medi-Cal formulary. Drugs that are not listed may be covered subject to prior authorization. Medi-Cal Rx | Contract Drugs List (CDL)

New!

Pharmacy Benefits

- Medi-Cal Rx and Prime Therapeutics (formerly Magellan)

Updated!

Medi-Cal for Kids and Teens (formerly EPSDT)

• Using MEDS for Coverage Information

Using MEDS for Coverage Information	
MEDS Screen	**Information Found on Screen**
HE	CCS Aid Codes: 9K – CCS Only; M/C with signed PSA on file; M/C with SOC 9R – TLICP over 40K 9U – TLICP with income unknown 9N – M/C only—no signed PSA on file 9M— MTP only
QM, Q1 or Q2	Medi-Cal eligibility status –The aid code definitions can be found in the Aid Codes Master Chart. The codes will tell you what type of M/C the client has such as OTLICP, Emergency Only or full scope Medi-Cal. A client may have different types of eligibility on different screens. For CCS billing purposes, full scope Medi-Cal trumps all. **Note:** The Aid Codes Master Chart is managed by DHCS. You must have a MEDS Home Page Account, issued to you by DHCS, to access it. Your county's Department of Human Assistance may post a link to the documents or there may be one or two individuals in your county who have access to this account. It is advisable you find the link or the individuals and request updated copies of the Meds Network User Manual and Master Aid Code chart periodically.
QX –SSI/DDS	SSI Status | Eligibility code 60 • indicated cash benefit • client receives cash to augment medical costs not covered by M/C (as in non-formulary drugs not payable with an override)
Q7	Past History – good for solving denials less than 24 months old when eligibility is the issue. • See ACSNet manual for 37 month history
HI	View Insurance Plan data
MOPI	Shift F12; BIC: enter date or date range: This is what providers see when they run eligibility for a client. CCS case should say 'may be CCS eligible'. Will have account numbers and phone numbers for OHC plans. **Note:** Errors in insurance information must be corrected by the family.
XB	BIC Issue Number and Date: From QM screen, type XB in Options. The BIC screen will populate.
INQN	Fuzzy Screen: Used to look up a client when information is missing

CRISS
CHILDREN'S REGIONAL INTEGRATED SERVICE SYSTEM

Search Site

Home | About Us | 2021 CCS Best Practices Conference | CRISS Tools | Contact Us | More

CRISS Claims Documents

References for County Staff:

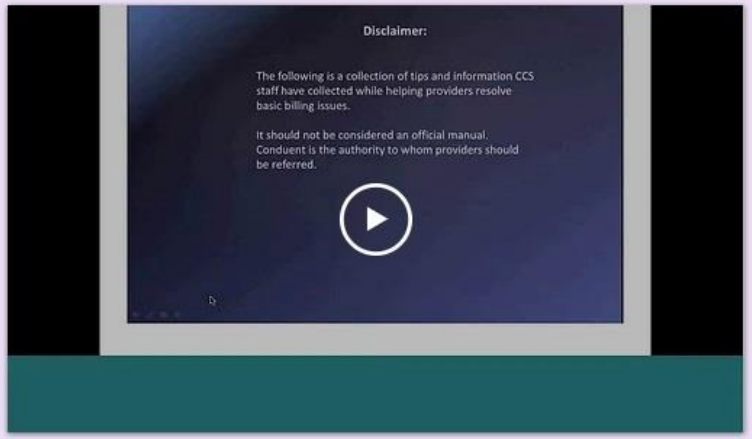
- **Claims Toolkit**
- CRISS Guide to CCS Aid Codes
- Calculating Units on CCS SAR
- MEDS Guide
- MEDS Manual
- ACSNet Manual

References for Providers:

- Emergency Medi-Cal Billing Guidelines
- Over One Year Training
- Provider Training PPT Part 1: January 2012
- Provider Training PPT Part 2: January 2012

CCS Claims Webinar

CCS Claims Webinar was held on Wednesday, May 3, 2017 from 9:30 am -11:00 am.



Part II – Authorizing Services

Information and Tips to Prevent Denials

Know Your SARs and Service Code Groups (SCGs)

A Service Authorization (SAR) enables providers to render and be reimbursed for specified services authorized by the CCS program.

The physician's authorization number (SAR number) may be shared, when appropriate, for reimbursement with other health care providers from whom the physician has requested ancillary services such as laboratory, pharmacy, radiology, or other physician specialty services.

SAR Tools https://www.dhcs.ca.gov/services/ccs/cmsnet/Pages/SARTools.aspx

Service Code Groups—Groups of HCPCS codes that authorize a provider to render any of the services included in the group.

Site-Wide Search

Showing Results for "cal child sar"

Search Medi-Cal Site
cal child sar

Search only Provider Manual

About 130 results (0.14 seconds)

California Children's Services (CCS) Program Service Authorization ...

mcweb.apps.prd.cammis.medi-cal.ca.gov › file › manual › fn=cal...

File Format: PDF/Adobe Acrobat

The CCS program requires authorization for health care services related to a client's CCS-eligible medical condition. Providers must submit a **SAR** to a CCS ...

Service Code Groups (SCGs)

- **SCG 01** – Physician (covers office visits, x-rays, MRIs, EEGs, Cat Scans, lab work)
- **SCG 02** – General Special Care Centers (includes all codes in the 01)
- **SCG 03** – Transplants Special Care Centers (Includes 01 & 02)
- **SCG 04** – Communication Disorder Centers (Audiology)
- **SCG 05** – Cochlear Implant Centers (Includes 04)
- **SCG 06** – High Risk Infant Follow-Up
- **SCG 07** – Orthopedic (Includes 01, covers most fracture repair codes)
- **SCG 08** – Rural Health/Federally Qualified Health Clinics
- **SCG 09** – Chronic Outpatient Dialysis Clinic (Need to add SCG 01 also)
- **SCG 10** – Ophthalmologic Surgery (Need to add SCG 01 also)
- **SCG 11** – Medical Therapy (OT & PT coding)
- **SCG 12** – Podiatry
- **SCG 51** – Surgery SAR, Exclude SCG (the codes listed are excluded). NL 02-0510

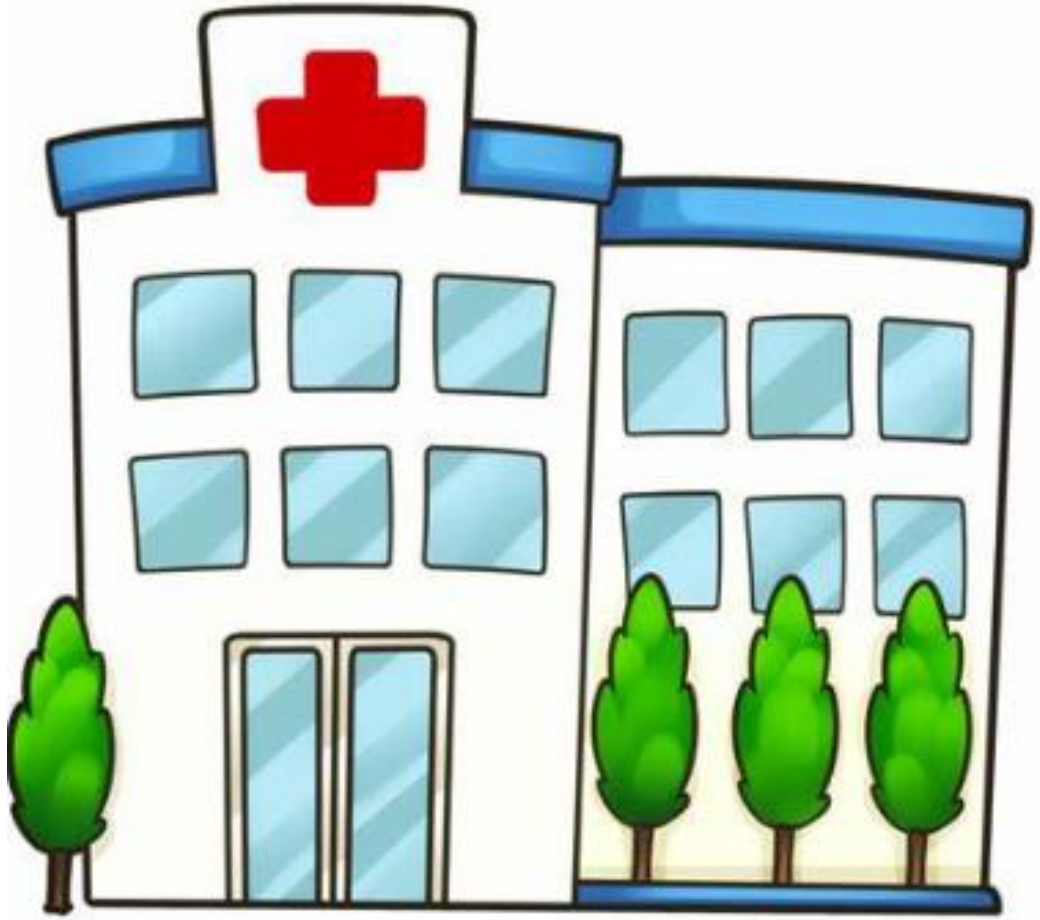
Inpatient and Out-Patient SARs

Inpatient and Out-Patient SARs	
Facility/Hospital SAR (Inpatient SAR)	• Inpatient SAR pays for days and bed only. • Issued to the Hospital. • No codes or SCGs are added to an Inpatient SAR. • Physicians/ancillary services cannot bill with an Inpatient SAR. • Physicians will need a SCG 01, 02, 04, etc, SAR to bill for services during I/P stay. • At Private Hospitals, SAR is issued for 1 day for Diagnosis Related Group (DRG) payment. See This Computes! 424, 426, 430, 440, 442 • Find This Computes in CMSNet under Bulletins • As of 1/2/15 CCS covers the entire stay at Designated Public Hospitals if child was only CCS medically eligible for part of the stay. Numbered Letter 04- 0715.
DRG SARs	For more information on DRG SAR follow the link: https://www.dhcs.ca.gov/provgovpart/pages/drg.aspx

Physician SAR (01)	• Issued to one physician only.
	• Physician is required to share with other providers.
	• Ancillary services of an I/P stay can bill using the 01 SAR. Examples:
	  ➢ Labs
	  ➢ Radiology
	  ➢ Therapy
	  ➢ Consults
	• Physicians can also bill with 02 if available when there is only a facility SAR for an Inpatient stay.
	• Physician can share SARs with other physicians for billing purposes

Special Care Center (SCC) SAR (02)	• All providers can bill using a 02 SAR. • Hospitals holding 02 are required to share with other providers.

Out-of-State Hospital Information



New in this edition!

ISCD SAR Cover Sheet

ISCD SAR Cover Sheet	Local CCS county programs use this cover sheet when sending requests to ISCD for the following reasons:
	• Independent Classic County—ISCD approves SARs for transplants, Cochlear Implant Surgery, out-of-State requests, Zolgensma and initial requests for Spinraza.
	• Dependent Classic County—Same as Independent Classic county, plus authorization requests (based on CMIP level), and initial eligibility and annual review.
	• Independent WCM County—
	  ○ For child enrolled in the Medi-Cal Managed Care Plan: any requests for clotting factor and Hemlibra that are submitted with a procedure code (if submitted with an NDC code, the provider/pharmacy will send the request to Magellan)
	  ○ For CCS-only or child with FFS Medi-Cal: same as Independent Classic County.
	• Dependent WCM County—same as first bullet for Independent WCM County, plus any requests related to initial eligibility or annual review, plus any authorization requests for eligible children not enrolled in the Medi-Cal Managed Care Plan (CCS-only or FFS).
	
	Check Numbered Letters for policies and instructions related to specific items listed above.

Pharmacy SARs

New in this edition!

- Medi-Cal Rx took over as the pharmacy benefits manager for Medi-Cal on January 1, 2021.
- Most pharmacy authorizations are issued by Medi-Cal Rx.
- Specifically, all pharmacy products billed with a NDC code.
- CCS continues to authorize pharmacy related products billed as a medical or institutional claim.
- **Prime Therapeutics** is the current pharmacy benefit manager (PBM) processing Medi-Cal Rx claims.

Pharmacy SARs	
Medi-Cal Rx	Magellan took over as the pharmacy benefits manager for Medi-Cal on January 1, 2021. The state named this program Medi-Cal Rx. Magellan was bought by Prime Therapeutics in 2024. Most pharmacy authorizations will be issued by Medi-Cal Rx. Specifically, all pharmacy products billed with a NDC code. CCS will continue to authorize pharmacy related products billed as a medical or institutional claim.
Medical Supplies	Limited supplies may be covered under a 01 or 02 SAR. Medical Supplies are never covered on an 08 SAR.
Albumin Test Strips	Albumin is a medical benefit, and not a pharmacy benefit. It is authorized with a T5999 SAR and has to be submitted as a manual claim.
For pharmacy inquiries, contact CMS Branch Pharmacy Consultant Kirstie Yi at Kirstie.yi@dhcs.ca.gov or (916)704-8724. For medical inquires, contact Dr. Jill Abramson via e-mail at Jill.Abramson@dhcs.ca.gov or telephone at (916)327-2108 for questions.	

Tip: an incorrect configuration of units and quantity can result in denials.

- **If the SAR configuration is correct and provider is still getting denied, verify:**
  - **Provider is using the code which is on the SAR**
  - **In ACSNet, verify there are still units available on the SAR**

Diabetic Supplies

New in this edition!

- Most diabetic supplies are authorized by Medi-Cal Rx.
- CCS authorizes some insulin pumps and Medi-Cal Rx authorizes CGMs

Diabetic Supplies	
For the most up to date list of covered benefits, refer to the Covered Products Lists on the Medi-Cal Rx website and Medical Supplies Billing Codes, Units and Quantity Limits.	
Authorized by Medi-Cal Rx	• **Continuous Glucose Monitoring (CGM) Systems:** Therapeutic and Non-Therapeutic • **Home Blood Glucose Monitors:** Self-Monitoring Blood Glucose Systems (Glucometers) • **Insulin Pumps:** V-Go, Omnipod, and Omnipod Dash • **Pen Needles** • **Blood Ketone Test or Reagent Strips**
Authorized by CCS	All other insulin Pumps that are not covered by Medi-Cal Rx

Durable Medical Equipment – Rehabilitation (DME-R) SARs

- CCS NL 09-0703
- Modifiers
- Vests – E0483
- DME Frequency Limits
- DME Billing
- Pricing not on file

DME-R SARs	
CCS NL 09-0703	CCS Guidelines for Recommendation and Authorization of Durable Medical Equipment – Rehabilitation (DME-R)—everything you need to know about authorizing DME.
Modifiers	A DME authorization will not pay if the modifier is missing. RR – rental equipment NU – New purchased equipment RP – equipment repair RB – labor
Vests – E0483	Rental only: expensive product, changes often, goes back to provider when done with, rental less expensive over time.
DME Frequency Limits—search with "dura cd fre" on the Medi-Cal webpage. For orthotics and Prosthetics, seach with "ortho cd fre1"	Frequency restrictions are applied to procedure billing codes within the designated timeframe. Frequency limits can be overridden (with the exception of diabetic shoe and insert codes) if the CCS paneled specialist provides a letter of medical necessity.
DME Billing	DME and medical supplies requires billing with invoices AND catalogue pages Provider must bill manually and include invoices (regardless of pricing)
Pricing not on file	When the pricing is not on file, the reimbursement rate for the code may be 'under review' or not yet submitted to MC for review. The provider must bill with current catalogue page (Med supplies/DME) copies to establish the reimbursement rate.

New in this edition!

N.L.: 03-0723

Telehealth SAR Information

Telehealth SAR Information	
Telehealth Basics and Policy and Procedure Links	Telehealth is a process for delivering health care to individuals virtually from a distance. This can include Rural Health Centers (RHC) and Indian Health Services. The process is available to CCS providers • CCS MTU: initial assessment must be done physically, thereafter treatment can be provided virtually. • Providers must use Place of service code 02 on claims • Use modifier 95 when billing for synchronous (real time) appointments with the patient • Use modifier GQ for asynchronous transmission of patient records when the patient is not present (also used for E-consults with the service providing care for the patient) • E-consults are used to assist in diagnosis and case management between physicians Here are some links to Telehealth documentation in the Medi-Cal Manual: Telehealth policy, codes and billing requirements. Telehealth relative to Covid-19 Telehealth relative to Auditory Rehabilitation Telehealth Definitions This Computes: codes included in Telehealth billing: Found in CMSNet Bulletins (top right corner of CMSNet Home Page).

Miscellaneous SAR Information

- Diagnostic SARs for children with OTLICP
- Vendored Therapy in Lieu of...
- By Report
- By Report Not Specified
- Units and Quantity
- Modify SAR begin date
- SAR extensions
- Canceled SAR
- EPSDT SARs
- Dental CPT code 41899
- Procedure Types
- Pend/Deny Indicators
- R codes vs T codes
- Provider Types
- Category of Service

Common SAR Mistakes

Modifiers are missing from DME SARs

In-Patient stay End Date is extended on Non-DRG SAR, but number of days is not recalculated.

SAR End Date is extended but Unit/Quantity is not increased.

Medi-Cal for Kids and Teens EPSDT SAR is issued as a regular SAR. EPSDT SARs must begin with 91 by checking the EPSDT box. (Hearing aids are an exception)

R and T codes: Restricted (R) codes are ok to use, but biller must submit with medical justification. Terminated (T) codes are no longer eligible for use.

Unit / Quantity is missing or incorrect.

Paneling Guidelines

- Web site link to Paneling Desk
- Paneling Desk Address & Phone Number
- DME Providers
- Therapists (including MTP therapists)
- Paneled Non PMF Providers
- Retro Paneling
- Temp Paneling
- Physician Assistant ***new guidance*** N.L.: 08-1023
- Nurse Practitioners ***new guidance*** N.L.: 07-1023

Paneling Guidelines	
Web site link to Paneling Desk	Link to application for paneling. Electronic process is quick and can be completed in a few days. Paneling Desk Web Page This page contains paneling guidelines as well as a link to the application Note: the provider must be enrolled in Medi-Cal before becoming paneled. The Provider Enrollment Division will assist the provider in enrolling.
Paneling Desk Address & Phone Number	Children's Medical Services Branch Provider Relations Unit 916-552-9105 providerpaneling@dhcs.ca.gov
DME Providers	Do Not Require paneling. Do require Medi-Cal license
Therapists	Non-Provider Master File (PMF) Provider – Use Allied Application. **Cannot issue SAR to a Non-PMF**
Paneled Non-PMF Providers	This category includes Audiologists, Orthoptists', Occupational Therapists, Speech Therapists, Psychologists, Dieticians, and Social Workers. SAR cannot be issued in the Provider's Name. It must be issued to the Center/Facility. Once the SAR is created there is a field for CCS staff to enter the name of the Paneled Non-PMF

Paneling and ER Visits

Paneling and ER Visits	
ER Visit – No Admission	Paneling is not an issue for treatment in an ER. An Out-Patient SAR will cover the facility, doctors and treatments. Billing with an O/P SAR does not require the physician's NPI.
ER Visit – Results in Admission	The Admitting/Attending must be CCS paneled. Non-paneled admitting/attending will result in a denial of the I/P stay and all billing by ancillary staff and services (physicians, labs, radiology, etc.)

Knowledge Check

Knowledge Check Answers

- 1. What does CRISS stand for?
  - Children's Regional Integrated Service System
- 2. Where can you find the toolkit, this recorded webinar, and the ACSNet and MEDs manuals?
  - On the CRISS website
- 3. Who can bill with an inpatient SAR?
  - Only the hospital
- 4. Which diabetic supplies are still authorized by CCS?
  - Some Insulin pumps

Part III – Claim Denial Troubleshooting

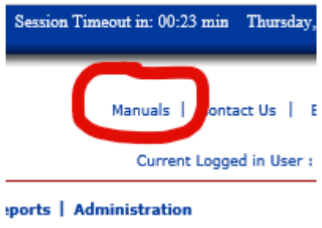
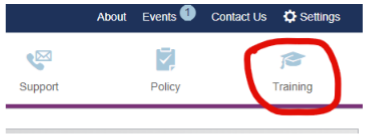
CCS Billing Basics for Providers

- Providers must know the keys to filling out the standard claim forms for CCS.
  - Rendering Provider
  - Referring Provider
  - SAR Number Field
  - Submit to Medi-Cal Fiscal Intermediary
- Electronic Submissions
  - SAR # will not be recognized for billing on the same day a SAR is issued

How to Use the SAR to get paid – search "CCS Claim Completion" on the Medi-Cal website for more information and Samples	
CMS-1500	• SAR # must be in Box 23 • Pharmacy uses this form if billing with a HCPCS • Ancillary providers and out-patient facilities, MDs, etc. can bill with 01 SAR by adding the referring physician in box 17b. The referring physician for this purpose is the physician that the SAR is issued to. • The physician whose name and NPI are on the SAR **must** be on the claim. If another physician is using it, the SAR owner must be listed as the Referring Physician, regardless if that physician made the referral or not. • For Non-physician billing, enter the NPI of the MD on the SAR in Box 24J, it is not necessary to enter the non-physician name and NPI on the SAR.
UB-04	• SAR # must be in Box 63 • Ancillary providers can bill with 01 SAR by adding the referring physician in box 76. The referring physician for this purpose is the physician that the SAR is issued to. • Remember –the name and NPI of the physician on the SAR **must** be on the billing.

Resources

- Numbered Letters
- This Computes! And Bulletins

This Computes! and Bulletins	This Computes! (TC!) and Bulletins are a good resource for researching SAR problems and denials They can be found in CMSNet. From the Home Page, select Bulletins in the top right corner, or select Training in CMS2020 (This Computes will be at the bottom of the list of Bulletins):  or  Inside you will find a link to the TC! Archive and a listing of Bulletins.

Outdated N.L.s and only listing active N.L.s.

If you need to access a N.L. that is no longer being displayed on this website, or the N.L. hyperlink displayed is not working, please send a request to CCSProgram@dhcs.ca.gov, including the CCS N.L. number and/or title you were trying to access, and we will forward to you a copy of the inactive N.L.

Sign up for e-mail notices (LISTSERV) when CMS Branch letters are posted.

2022 | 2021 | 2020 | 2019 | 2018 | 2017 | 2016 | 2015 | 2014 | 2013 | 2012 | 2011 | 2010 | 2009 | 2008 | 2007 | 2006 | 2005 | 2004 | 2003 | 2002 | 2001 | 2000 | 1999 | 1997 | 1994 | 1992

2024

Number	Release Date	Index Category	Title (Subject) of Letter
02-0324	03-19-24	Medical Therapy Program	Duplication of and/or Conflict with the Provision of Medically Necessary Therapy Services Provided in the CCS Medical Therapy Program
01-0324	03-08-24	Benefits	CCS Blood, Tissue, and Organ Transplants Attachment 1: Adjudication Responsibilities by SAR and County Type Attachment 2: List of Commonly-Used Transplant Current Procedural Terminology

2023

mber	Release Date	Index Category	Title (Subject) of Letter
1223	12-27-23	Case Management	California Children's Services Program Whole Child Model (Revised December 2023) Note: Supersedes N.L. 03-0421
1223	12-19-23	Medical Supplies	Authorization for Purchase of Incontinence Medical Supplies

Remittance Advice Details (RAD Codes)

- Remittance Advice Details (RAD Codes)
- Correspond to denial reasons
- RAD Repository

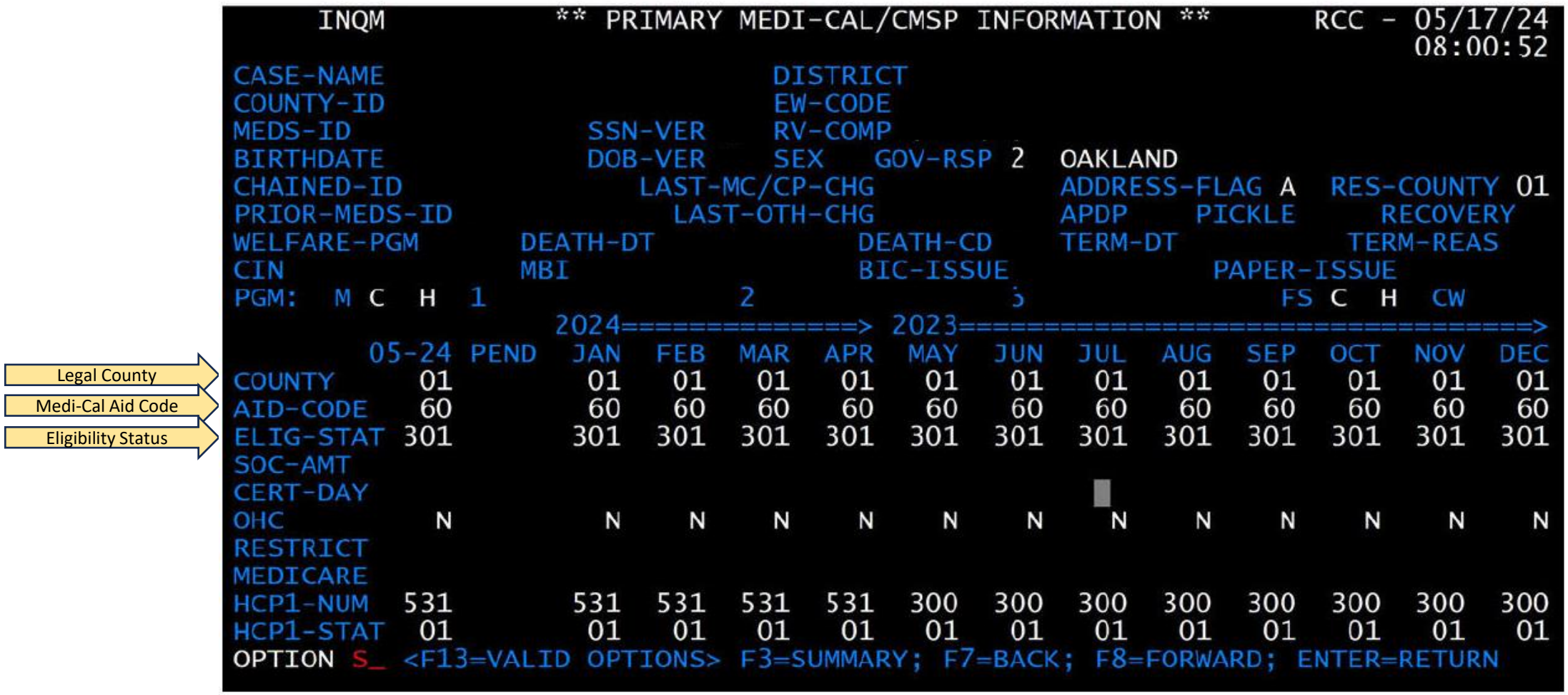
Common Denials and Solutions by RAD Code		
RAD Code Table	**The new RAD Code Table has both manual and electronic billing denial codes in one document. Open the link below then go to the hyperlink Remittance Advice Details to open the table.**	
RAD Codes do not always make the denial reason clear. Some of the more common denials seen by CCS are below. They point to possible solutions to the denial.		
RAD Code	**Possible Reason**	**Possible Solution**
005	Provider says service is not authorized by CCS. Why not?	SAR # was not entered. SAR was just entered or modified – wait 24 hours for SAR to upload to M/C
007	Missing or invalid cardholder id.	Verify correct ID (BIC) is being used. Go to MEDS and get current BIC issue date and full BIC # with the 5 digits after the alpha digit. (See MEDS Manual for how to do this or type XB from the QM Screen).
10	Previously Paid	If denial is within 12 week window, find it in ACSNet and give the provider the Warrant # and Date of payment
036	RTD not submitted	RTD – Return Turnaround Document. MC will send these to billers to make a correction in a hardcopy claim. Returning it will avoid rebilling. Advise provider to find RTD to determine denial reason of original claim. If not able to locate, rebill claim. Benefit of returning the RTD is that it keeps the claim timely (provided RTD is returned timely)
9942	Quantity billed is greater than allowed: V5298 (Hearing Aid)	Can bill for one unit only. Invoice must document 2 units and provider will be paid for 2 units.
031	Provider not eligible for DOS	Check CMSNet Provider's file. Was provider paneled on DOS Was provider Category of Service (COS) correct for DOS (may need to contact CMSHelp to determine provider's eligibility to bill for the code.

MEDS

- Check MEDs for issues related to coverage

Issues Related to Coverage—Check MEDS		
Denial Type	**Possible Reason**	**Possible Solution**
Bill other insurer	Provider doesn't have other insurance info	View Insurance - HI HI screen will give insurer/phone number/start & stop date Or View Insurance - MOPI (Sometimes has more detailed info than HI screen) In MEDS - Shift F12 M Enter
Bill other insurer	Sometimes OHC is added without the knowledge of the client (as in absentee non-custodial parent getting coverage). Sometimes the parent forgets to notify CCS of addition of HMO/PPO.	If client does have OHC showing in Medi-Cal but they do not believe it is accurate, it is the client's responsibility to contact Medi-Cal to have any corrections made. Client is responsible for contacting CCS with any new OHC policy additions.
Bill other insurer (but MEDS is not showing OHC)	Possible scenario FOC/MOC is buying insurance per court order and custodial parent does not know.	Advise the provider to bill Primary Ins to see if there is a valid policy. If policy is not valid the custodial parent MUST get the OHC removed from case before any claims will pay.
No Eligibility	BIC Issue Date	This is a common denial reason for 'no eligibility'. Check that the provider has the correct **BIC issue date** (Some provider's proprietary software requires entry of issue date – not all do) In MEDS QM screen, select XB
No Eligibility	Adopted	Case will have 04 eligibility code; Check for incorrect CINs (provider could be billing with original CIN). Make sure the CIN on the SAR is the new CIN, not the original. An adopted child's CIN is never merged to the new CIN for confidentiality purposes. Use the new CIN. **Never share the pre-adoption CIN**

MEDS



Legal County

Medi-Cal Aid Code

Eligibility Status

Aid Codes Master Chart

Page updated: April 2022

The Aid Codes Master Chart was developed for use in conjunction with the Medi-Cal Automated Eligibility Verification System (AEVS). Providers must submit an inquiry to AEVS to verify a recipient's eligibility for services. The eligibility response returns a message indicating whether the recipient is eligible, and for what services. The message includes an aid code if the recipient is eligible. If a recipient has an unmet Share of Cost (SOC), an aid code is not returned, since the recipient is not considered eligible until the SOC is met. A recipient may have more than one aid code, and may be eligible for multiple programs and services.

The aid codes in this chart are meant to assist providers in identifying the types of services for which Medi-Cal and public health program recipients are eligible. The chart includes only aid codes used to bill for services through the Medi-Cal claims processing system and for other non Medi-Cal programs that need to verify eligibility through AEVS.

Note: Unless stated otherwise, these aid codes cover United States citizens, United States nationals and immigrants in a satisfactory immigration status. ‹‹Satisfactory immigration status includes lawful permanent residents, Permanent Residence Under Color of Law (PRUCOL) non-citizens and certain amnesty non-citizens.››

Aid Codes Master Chart

Code	Benefits	SOC	Program/Description
A1	Hearing aid and audiology	No	Non-Medi-Cal Hearing Aid Coverage for Children Program *
C1	Restricted to pregnancy-related, postpartum and emergency services	No	‹‹Omnibus Budget Reconciliation Act (OBRA) Non-Citizens and Unverified Citizens. Covers eligible non-citizens who do not have satisfactory immigration status and unverified citizens.›› Aid to the Aged – Medically Needy (MN). Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
C2	Restricted to pregnancy-related, postpartum and emergency services	Yes	‹‹OBRA Non-Citizens and Unverified Citizens. Covers eligible non-citizens who do not have satisfactory immigration status and unverified citizens.›› Aid to the Aged – MN, SOC. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.

‹‹**Aid Codes Master Chart (continued)**››

Code	Benefits	SOC	Program/Description
6J	Full	No	SB 87 Pending Disability. Covers with no SOC beneficiaries age 21 through 65 years old who have lost their non-disability linkage to Medi-Cal and are claiming disability.
6N	Full	No	Former SSI No Longer Disabled in SSI Appeals Status.
6P	Full	No	Personal Responsibility and Work Opportunity Reconciliation Act/
6R	Full	Yes	SB 87 Pending Disability (SOC). Covers with an SOC those age 21 through 65 years old who have lost their non-disability linkage to Medi-Cal and are claiming disability.
6U	Restricted to pregnancy-related, postpartum and emergency services	No	Restricted FPL – Disabled. Covers the disabled in the A&D FPL program who do not have satisfactory immigration status. Provides pregnancy-related services, including services for conditions that may complicate the pregnancy, postpartum services and emergency services.
6V	Full	No	Department of Developmental Services (DDS) Waivers (No SOC).
6W	Full	Yes	DDS Waivers (SOC).
6X	Full	No	Medi-Cal In-Home Operations (IHO) Waiver (No SOC).
6Y	Full	Yes	Medi-Cal IHO Waiver (SOC).
60	Full	No	Disabled – SSI/SSP – Cash.
63	Full	Y/N	Disabled – LTC.
64	Full	No	Disabled – MN.
65	Full	Y/N	Katrina-Covers eligible evacuees of Hurricane Katrina.
66	Full	No	Disabled – Pickle Eligibles.
67	Full	Yes	Disabled – MN, SOC.
68	Full	No	Disabled – IHSS.
69	Restricted to emergency services	No	200 Percent Infant OBRA. Provides emergency services only for eligible infants without satisfactory immigration status who are age 0 through 12 months old or beyond 1 year when inpatient status, which began before 1st birthday, continues and family income is at or below 200 percent of the FPL.

ELIG 0190

1st Digit = Medi-Cal/CMSP/Other Eligible Status 0191

- **0** Full Scope Medi-Cal Eligible (includes zero SOC) with no conditions (refer to **3** below for conditions)
- **1** Full Scope Medi-Cal LTC/SOC Eligible (i.e., Share of Cost to be met by LTC claim)
- **2** LTC/SOC Eligible with one or more conditions (refer to **3** below for conditions)
- **3** Eligible with one or more conditions – Certified SOC, Restricted Services, Minor Consent, CMSP Coverage, Limited Scope Medi-Cal Coverage and/or Partial Health Care Plan (HCP) Coverage
- **4** Medi-Cal Eligible with Full Service Medi-Cal HCP Coverage
- **5** Medi-Cal or CMSP Client with an Unmet Share of Cost Obligation (Uncertified SOC)
- **6** Eligible for a Health or Welfare Program other than Medi-Cal or CMSP services (i.e., SLMB, QDWI, Out-of-State Foster Care, Unborn, County MI Program, CHDP State Only, MCE State and County, HCCI Existing, HCCI New, and AIM Pregnant Mother)
- **7** Hold
- **8** QMB pending Medicare part A & B confirmation
- **9** Ineligible

2nd Digit = Normal/Exception Eligibility 0192

- **0** Normal eligible
- **1** Unconfirmed Immediate Need eligible reported more than 1 month prior
- **2** Unconfirmed Immediate Need eligible reported 1 month prior
- **3** Unconfirmed Immediate Need eligible reported in current month
- **4** Forced eligible due to late termination
- **5** Partial Month Eligibility (Presumptive Eligibility, etc.)
- **6** MEDS changed aid code to limited scope due to DRA Citizenship/Identity requirements not met
- **7** Exception eligible
- **8** Forced eligible from MEDS hold
- **9** Full Month Eligibility

3rd Digit = Timeliness/Misc. Information 0193

- **1** Regular eligible reported timely
- **2** Regular eligible reported retroactively
- **3** 3 month retroactive eligible
- **4** Continuing eligible reported timely
- **5** Continuing eligible reported retroactively
- **6** Ramos/Pickle/IHSS/Other Extended eligible
- **7** Aid Paid Pending Ramos/Myers
- **8** Hold from LTC/SOC status
- **9** Ineligible or Regular hold

ABAWD 1359

Able-Bodied Adults Without Dependents

- **0** Not ABAWD
- **1** ABAWD

ADDRESS FLAG 0305

Good Deliverable Address
- **A** Address certified via Finalist
- * **C** County Override, not certified via Finalist
- **D** Presumed mailable; Finalist changes unreliable
- **W** BIC mailed - previously A
- **X** BIC mailed - previously C
- **Y** BIC mailed - previously D

Presumed Deliverable Address
- **Blank** Failed Finalist; presumed mailable
- **0** BIC mailed - previously Blank

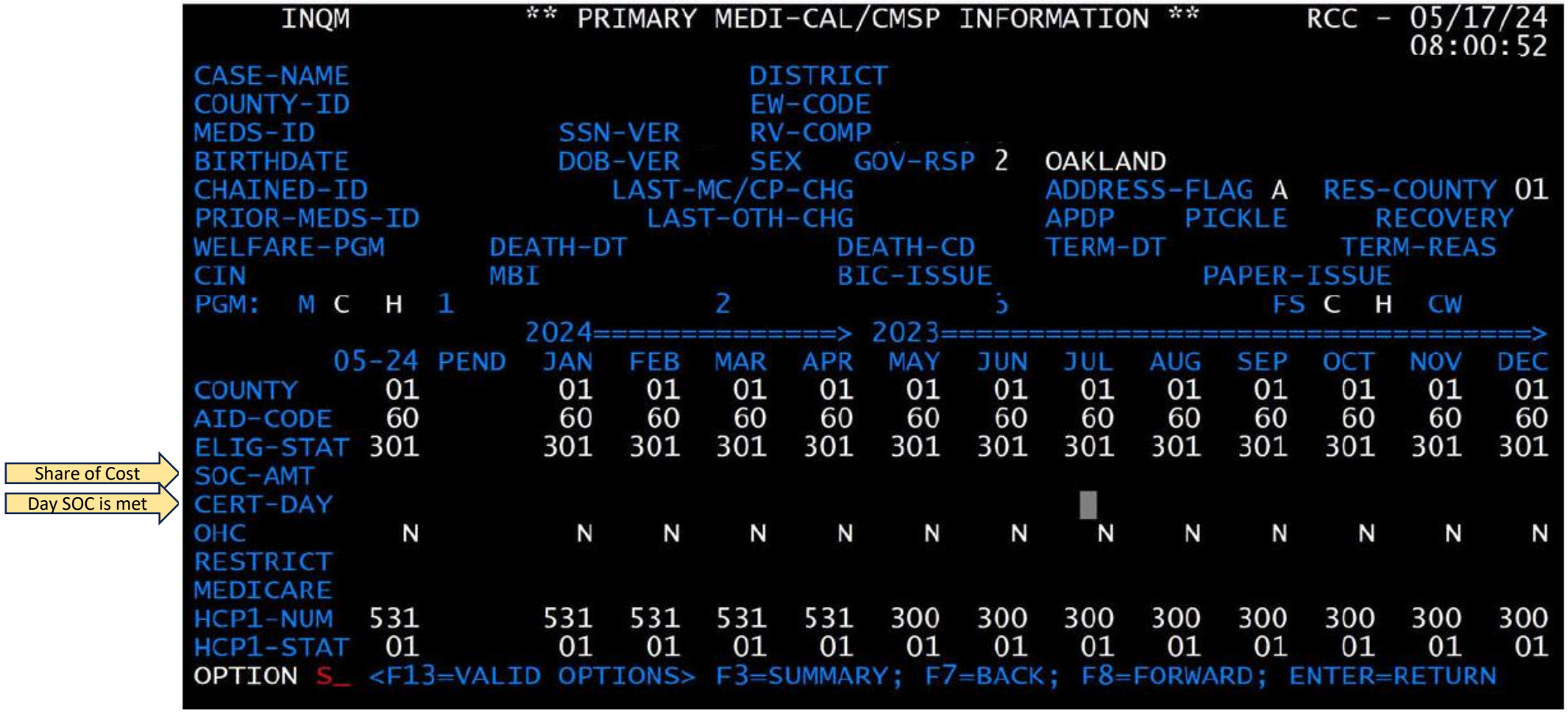
Considered Undeliverable Based on Returned Mail
- **1** BIC returned - previously 0
- **5** BIC returned - previously W
- **6** BIC returned - previously X
- **7** BIC returned - previously Y
- **9** NOA returned - previously Good Deliverable or Presumed Deliverable Address

Considered Undeliverable For Other Reasons
- **2** Failed MEDS validation edits
- **3** Foster Care Assistance terminated
- * **4** Residence address but not a mailable address
- * **8** General residence area for a homeless client

* These are the only valid input values (4 and 8 apply only to a residence address)
Finalist is the MEDS address certification software.

NOTE: Address Flag should only be input when the Finalist standardized address is incorrect (and needs to be overridden) (value C) or for a residence address when it is considered undeliverable (value 4 or 8).

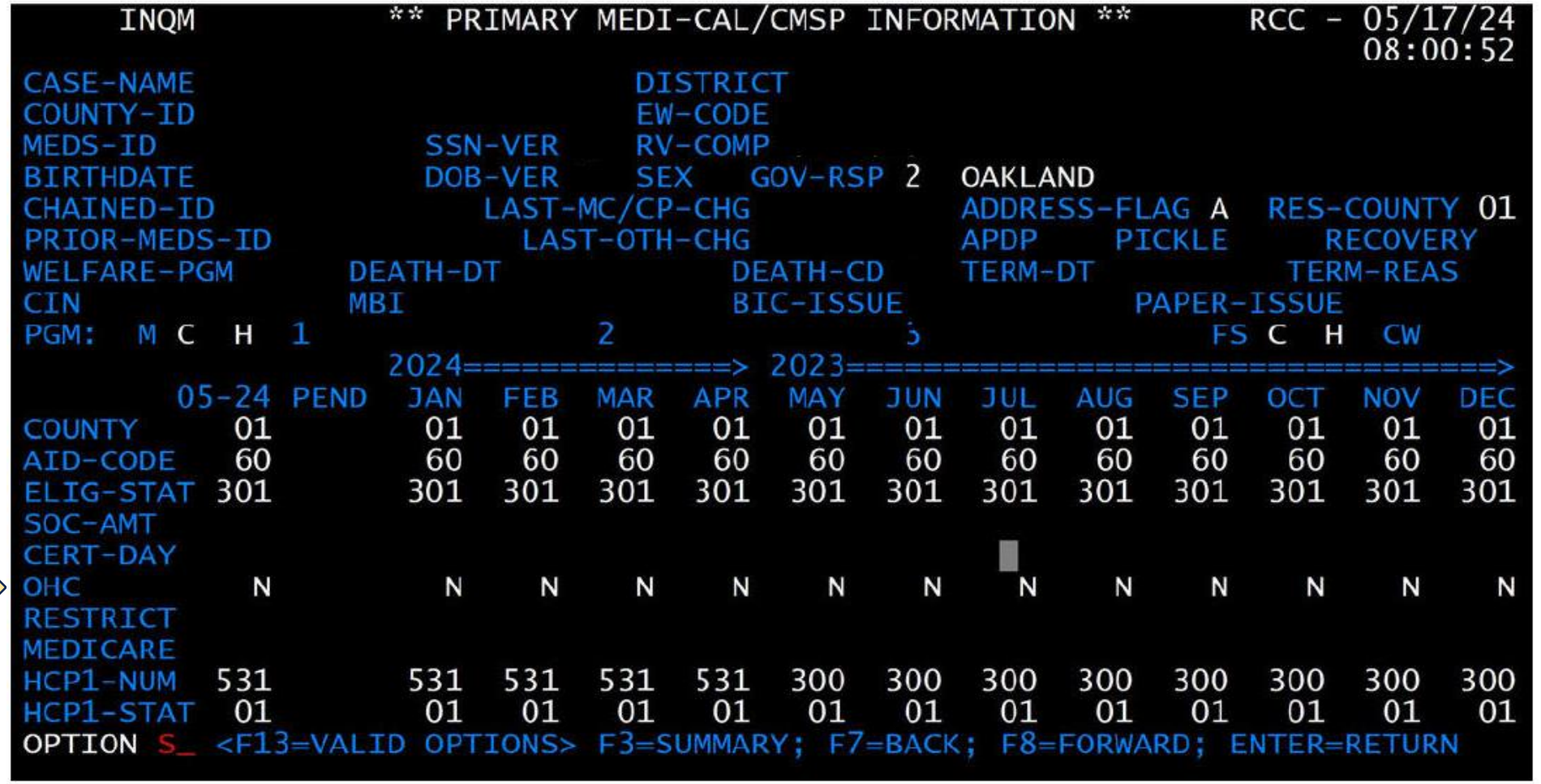
MEDS



Share of Cost

Day SOC is met

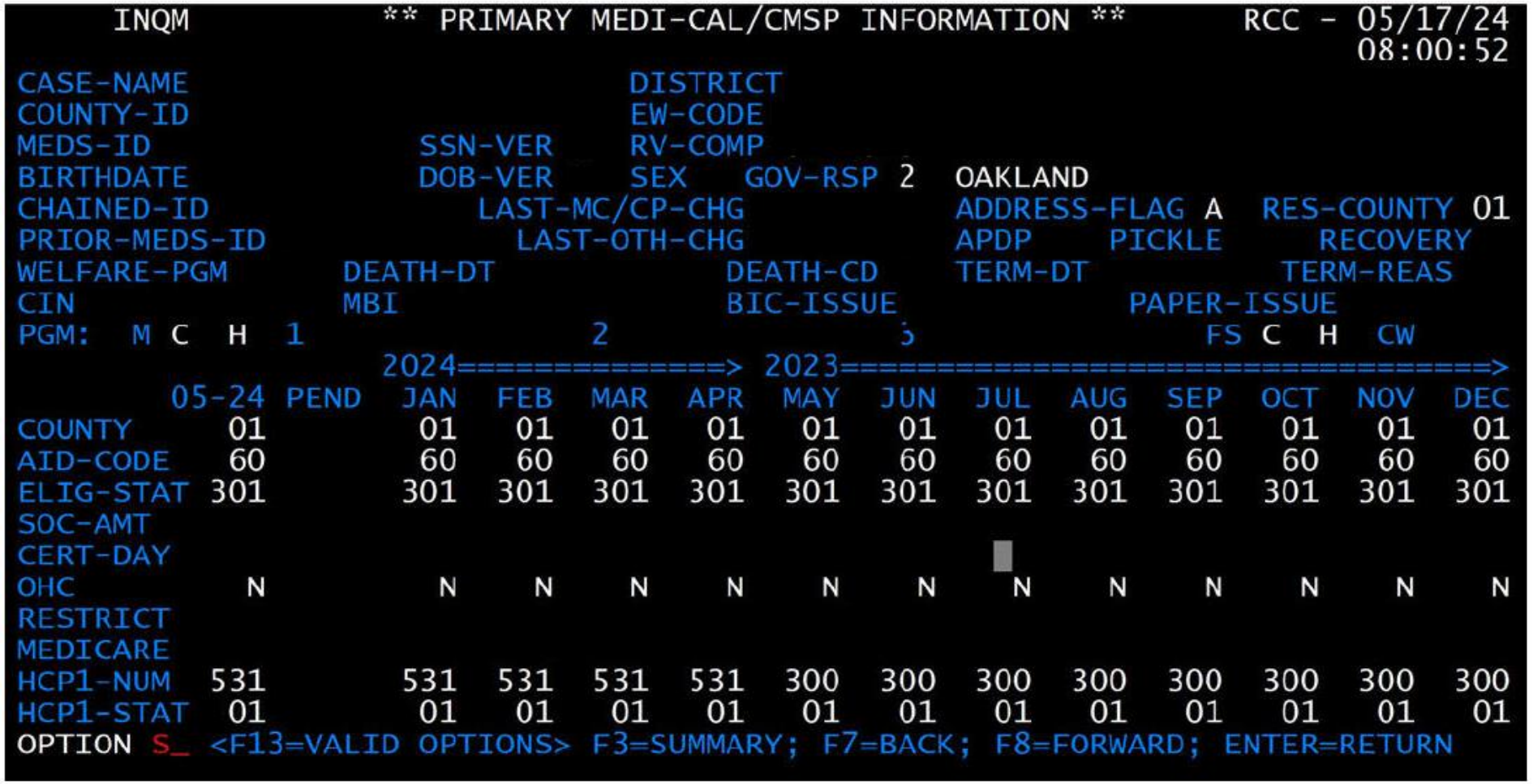
MEDS



Other Health Coverage

Anything Other than N requires further checks

MEDS



Managed Care Plan

MCP Enrollment Status

ACS Net

- Check if a claim was previously paid within a 12-week window
- Check for RAD code if claim was denied
- Verify if a Provider is enrolled with Medi-Cal
- Check how many units are in a SAR

Scenarios in which ACSNET is a Resource		
Denial Type	**Possible Reason**	**Possible Solution**
No Eligibility	• Incorrect CIN • Incorrect BIC Issue • Client has no active MEDS for month of service	• Is provider using the CIN on the SAR. Use CalPOS (ACSNet) • Does the provider have the correct **BIC issue date** (if the provider's proprietary software requires entry of issue date – not all do)
No Authorization	• Units have been used • SAR is expired	• Check ACSNet for Units Used • If units have been used determine if more units should be added to SAR • Check SAR effective dates • Is a new request required or can SAR be adjusted
Previously Paid	• Claim was already paid.	• If denial is within 12 week window, find it in ACSNet and give the provider the Warrant # and date of payment. • If outside the 12-week window the provider will need to contact MC for payment details
Item/Product not covered	• Item must be billed manually.	• Verify correct SAR is being used • Provider is trying to bill item not covered by Medi-Cal. Provider must select a covered item • Provider must bill to Medi-Cal or OHC
Requires Prior Auth	• Incorrect SAR #	Check ACSNet for: • Correct SAR • Over units limit for the month

Knowledge Check

Knowledge Check Answers

1. Where should providers submit their CCS claims for members in Classic Counties?

- Medi-Cal Fiscal Intermediary

2. Where should providers submit their CCS claims for members in WCM Counties?

- Medi-Cal Managed Care Plan

3. RAD codes are numeric codes assigned to a denial. RAD stands for:

- Remittance Advice Details


Time for
a break

Part IV – Client Gets a Bill

Tips for Helping the CCS Client if Client is Billed in Error

Addressing Billing Inquiries for CCS-Eligible Conditions

- Outline steps for handling client or parent inquiries about received bills.
- Provide clarity on effective responses.
- Ensure families receive necessary support.

Understanding Billing Issues

- Bills may indicate involvement of third-party billing companies, often out of state.
- These companies may not receive our Service Authorization Request (SAR) or understand CCS procedures.
- Incorrect claim submissions can lead to denials and bills sent directly to parents.
- This can result in collections

Billing Challenges with CCS Services

- This issue can occur with any CCS-authorized service.
- Many billing service providers are out of state and unfamiliar with CCS processes.
- CCS constitutes a small percentage of overall claims in California.
- Some billing personnel may lack knowledge of specific CCS billing requirements.

Guidance for Parents Regarding Billing

- Encourage parents to take proactive steps when addressing a bill.
- Advise them to contact the billing entity and inform them of their child's CCS enrollment.
- Provide the corresponding Service Authorization Request (SAR) number.
- If issues persist due to claim inaccuracies, CCS may need to intervene and contact the biller on the parent's behalf.

CCS Billing Assistance

- **Parental Awareness:** Encourage parents to contact CCS for help with billing issues.
- **Documentation:** Obtain a copy of the actual bill for thorough review.

Steps to Address Billing Issues

1.Verify Key Information:

1. Confirm there is a SAR on file.
2. Check if Medi-Cal was active on the date of service.
3. Ensure CCS was active on the date of service.
4. Review CMS Net for any prior case notes related to the bill.

2.Contact the Biller:

1. Use the phone number on the bill.
2. Have the SAR and patient information (DOB, address, phone) ready.

- **Claim Resolution:**
  - Biller typically agrees to re-submit the claim with necessary corrections.
- **Important Actions:**
  - Obtain the name and contact number of the representative.
  - Reiterate that the patient is not responsible for the bill.
  - Ensure any collection dates are removed to prevent automatic submission to collections.
- **Follow-Up:**
  - Ask the biller to contact you if they continue to receive denials from State Medi-Cal.

Encouraging Provider Communication

800-541-5555

- **Contact Medi-Cal Help Desk at 800-541-5555:**
  - Providers should reach out if claims are denied after common corrections.
- **Importance of Feedback:**
  - Gainwell relies on this feedback to identify and address provider challenges.
- **Regional Representative Option:**
  - If the help desk cannot resolve an issue, providers can request a contact from their Regional Representative.
  - This generates a ticket number, ensuring timely follow-up.
- **Specialized Support:**
  - Regional Representatives have more extensive training in CCS claims compared to help desk representatives.

Steps for Handling Bills Sent to Collections

- **Contact the Billing Agency:**
  - Identify the billing agency listed on the collection notice.
- **Request Removal from Collections:**
  - Ask the billing agency to pull the bill out of collections, as they often can.

California Welfare and Institutions Code Section 14019.4

The link to the law is in the toolkit

Addressing Aggressive Billing Practices

- **Reminder of Legal Protections:**
  - Inform the billing agency about Welfare and Institutions Code 14019, which prohibits collection efforts from Medi-Cal recipients with full-scope Medi-Cal on the date of service.
- **Toolkit Resources:**
  - Provide parents with a sample letter from your toolkit.
  - The letter can be used as a template to communicate with the billing agency, including a reference to the relevant code.

California Welfare and Institutions Code Section 14019.4

(a) A provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or a person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.

(b) Whenever a service or set of services rendered to a Medi-Cal beneficiary results in the submission of a claim in excess of five hundred dollars ($500), and the beneficiary has given the provider proof of eligibility to receive the service or services, the provider shall issue the beneficiary a receipt to document that appropriate proof of eligibility has been provided. The form and content of those receipts shall be determined by the provider but shall be sufficient to comply with the intent of this subdivision. Nursing facilities and all categories of intermediate care facilities for the developmentally disabled are exempt from the requirements of this subdivision.

(c) In addition to being subject to applicable sanctions set forth in law or regulation, a provider of health care services who obtains a label from, or copy of, the Medi-Cal card or other proof of eligibility pursuant to this chapter, and who subsequently pursues reimbursement or payment for the cost of covered services from the beneficiary or fails to cease collection efforts against the beneficiary for covered services as required by subdivision (d), may be subject to a penalty, payable to the department, not to exceed three times the amount payable by the Medi-Cal program. In implementing this subdivision, mitigating circumstances, which include, but are not limited to, clerical error and good faith mistake, shall be considered when assessing the penalty. Providers subject to penalties under this subdivision shall have the right to appeal the assessed penalty, consistent with department procedures.

(d) When a Medi-Cal provider receives proof of a patient's Medi-Cal eligibility and that provider has previously referred an unpaid bill for services rendered to the patient to a debt collector, the Medi-Cal provider shall promptly notify the debt collector of the patient's Medi-Cal coverage, instruct the debt collector to cease collection efforts on the unpaid bill for the covered services, and notify the patient accordingly.

Office of the Ombudsman

- 888-452-8609
- Mmcdombudsmanoffice@dhcs.ca.gov

Documentation Best Practices

- **Record Keeping:**
  - Maintain a detailed record of interactions as issues may require multiple attempts to resolve.
- **Case Note Format:**
  - Use the subject header “Bill/Claim Communication” in CMS Net for easy retrieval.
- **Key Information to Include:**
  - Name and phone number of the account representative
  - Date of the conversation
  - Billing provider and date of service
  - Problem and solution statement
  - Service Authorization Request (SAR) number provided.

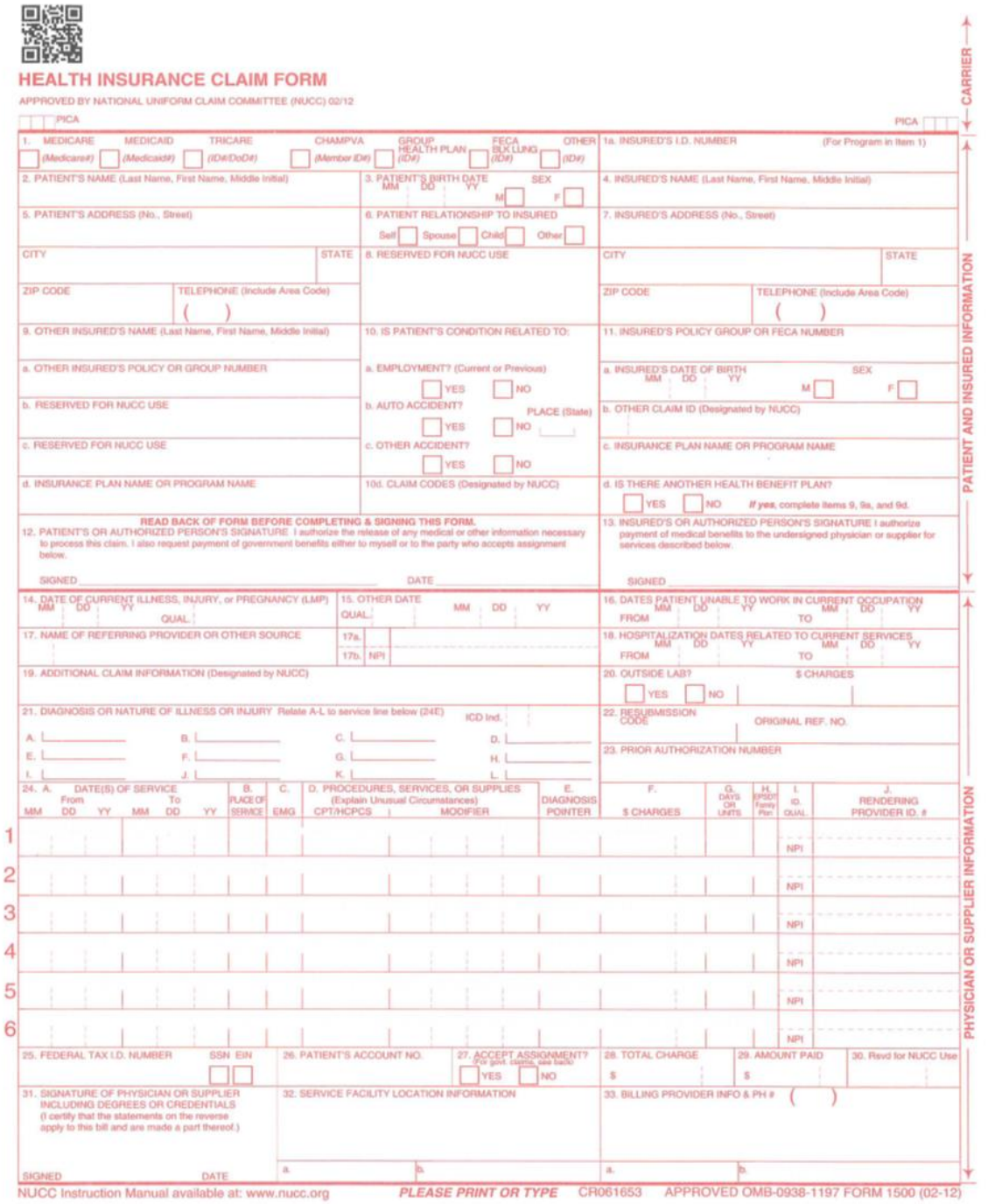
Follow-Up Procedures

- **Close the Loop:**
  - Contact the parent or client to inform them of the actions taken regarding the bill.
- **Encourage Communication:**
  - Ask them to notify you immediately if they receive any re-billing notifications.

Part V: Medical Therapy Conference Billing

Health Insurance Claim form Completion for MTC Physician Billing

Health Insurance Claim Form 1500



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

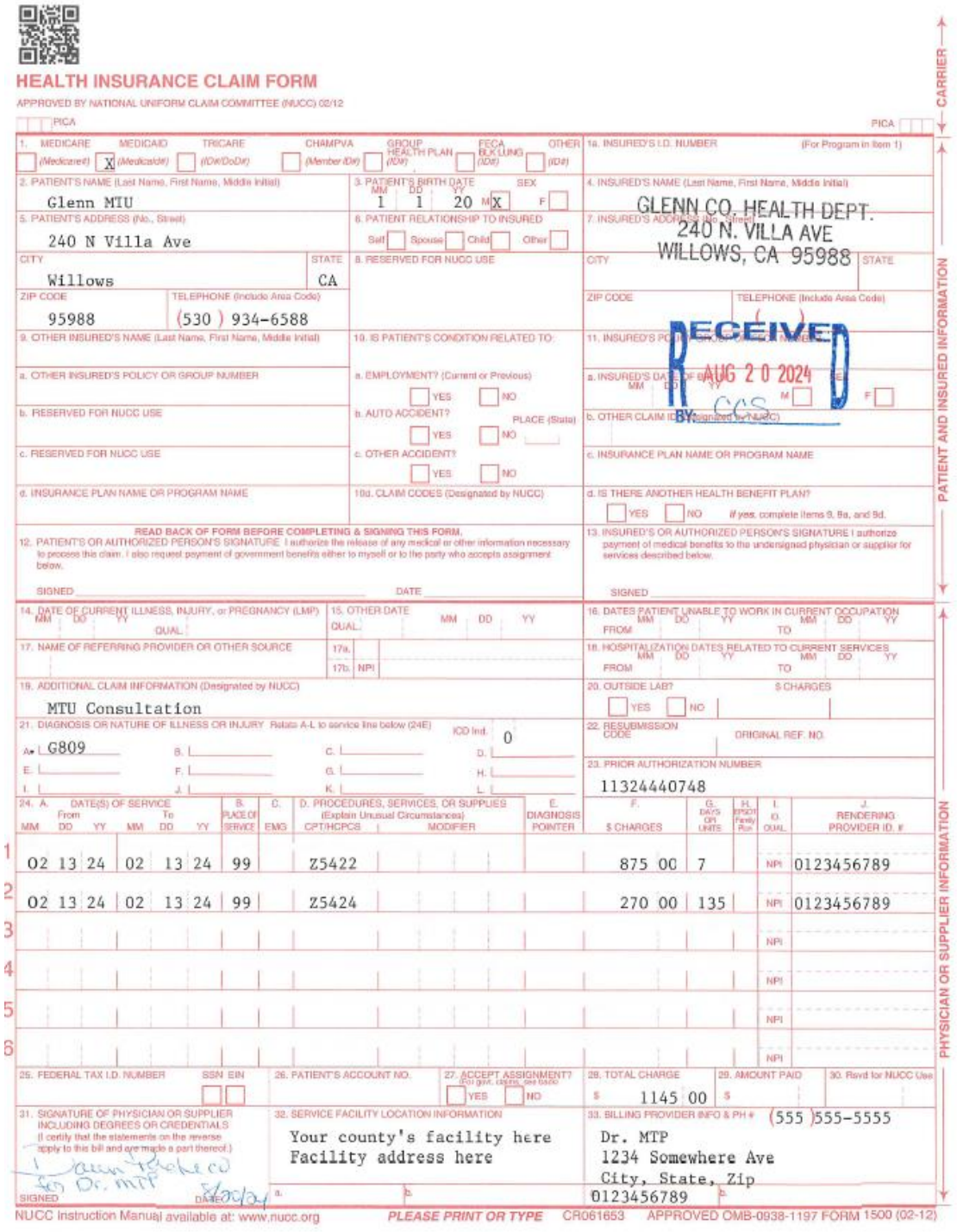
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

Completed Health Insurance Claim Form



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

3. PATIENT'S BIRTH DATE: 1 1 20 | SEX: M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): GLENN CO. HEALTH DEPT.

5. PATIENT'S ADDRESS (No., Street): 240 N Villa Ave

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

7. INSURED'S ADDRESS (No., Street): 240 N. VILLA AVE

CITY: Willows | STATE: CA

8. RESERVED FOR NUCC USE

CITY: WILLOWS | STATE: CA

ZIP CODE: 95988 | TELEPHONE (Include Area Code): (530) 934-6588

ZIP CODE: 95988 | TELEPHONE (Include Area Code)

RECEIVED AUG 20 2024 BY: CAS

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): MTU Consultation

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. G809 B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 11324440748

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	02 13 24	02 13 24	99		Z5422			875 00	7		NPI 0123456789
2	02 13 24	02 13 24	99		Z5424			270 00	135		NPI 0123456789
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $ 1145 00

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Dawn Rhoades CO for Dr. MTP 8/20/24

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Your county's facility here
Facility address here

a. b.

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

Dr. MTP
1234 Somewhere Ave
City, State, Zip
0123456789

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

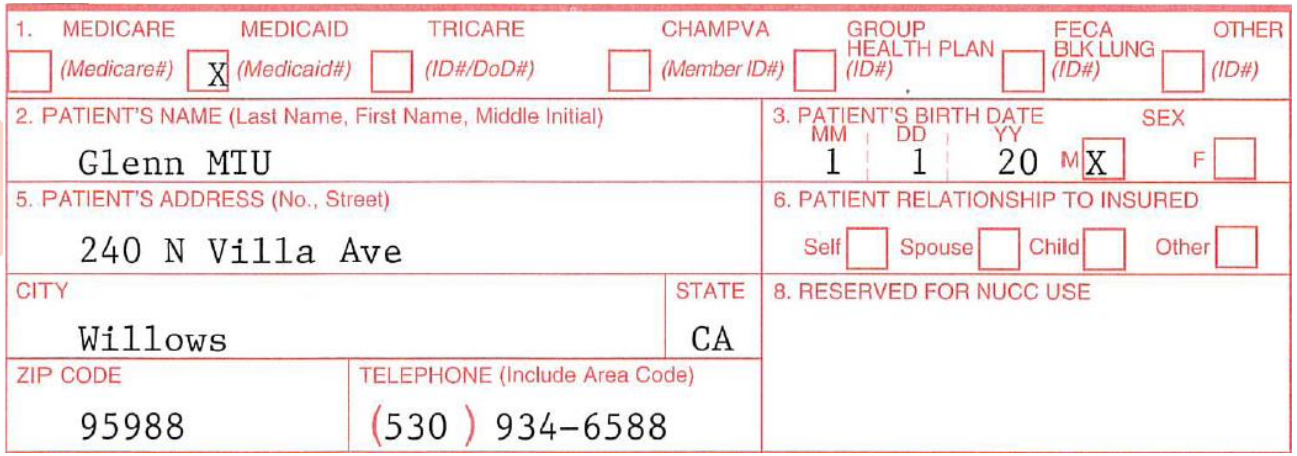
Boxes 1 through 5

Box 1: Check the Medicaid box

Box 2: Add name of MTP/MTU

Box 3: For patient's birthdate, use 1/1/2020. Then mark the M box under Sex.

Box 5: MTP/MTU street address. Make sure to divide the city, state, zip code and phone number into the correct boxes.



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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY	SEX
Glenn MTU	1 1 20	M X F
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	
240 N Villa Ave	Self Spouse Child Other	
CITY: Willows	STATE: CA	8. RESERVED FOR NUCC USE
ZIP CODE: 95988	TELEPHONE (Include Area Code): (530) 934-6588	

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

MTU Consultation

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. G809 B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

11324440748

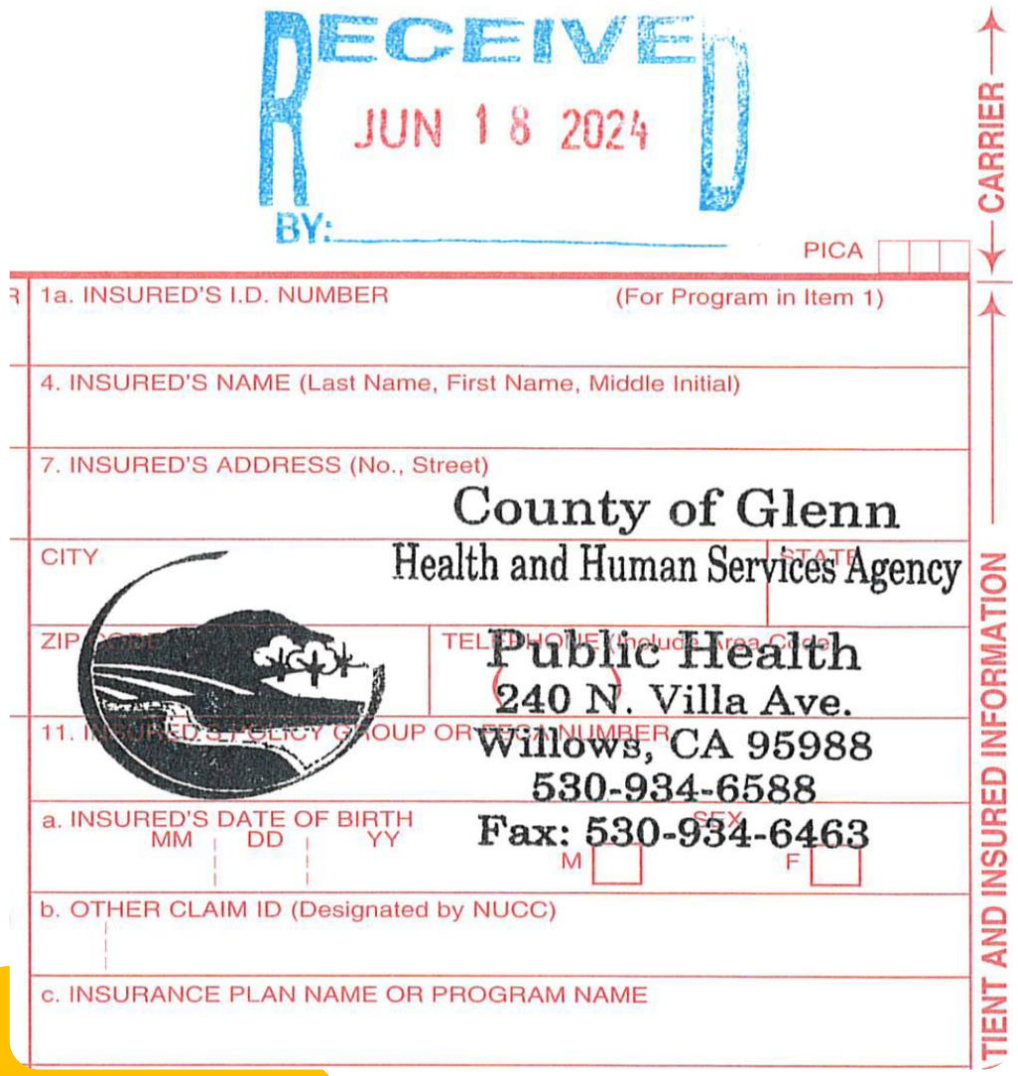
24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
02	13	24	02	13	24	99		Z5422			875 00	7		NPI	0123456789
02	13	24	02	13	24	99		Z5424			270 00	135		NPI	0123456789

Boxes 19 through 24

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
		☐ YES ☐ NO	$ 1145 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (555)555-5555
I Dawn Rocheo for Dr. MTP SIGNED DATE 8/20/24	Your county's facility here Facility address here a. b.	Dr. MTP 1234 Somewhere Ave City, State, Zip 0123456789 b.

Boxes 28 through 33A



County and Date Stamps

- Once form has been completed, stamp the claim form with the County Public Health or County CCS or CCS MTP stamp. Additionally, make sure to add a date stamp.
- NOTE: Without these stamps, the claim may be denied.

Once completed, send Original Health Insurance Claim form to:

DHCS Fiscal Intermediary

Gainwell

PO Box 15700

Sacramento, CA 95852-1700

Knowledge Check

Knowledge Check Answers

1. If a client gets a bill for a CCS-covered service, they should (choose the best answer):
   - call the provider or the CCS office so that the claim can get re-billed correctly

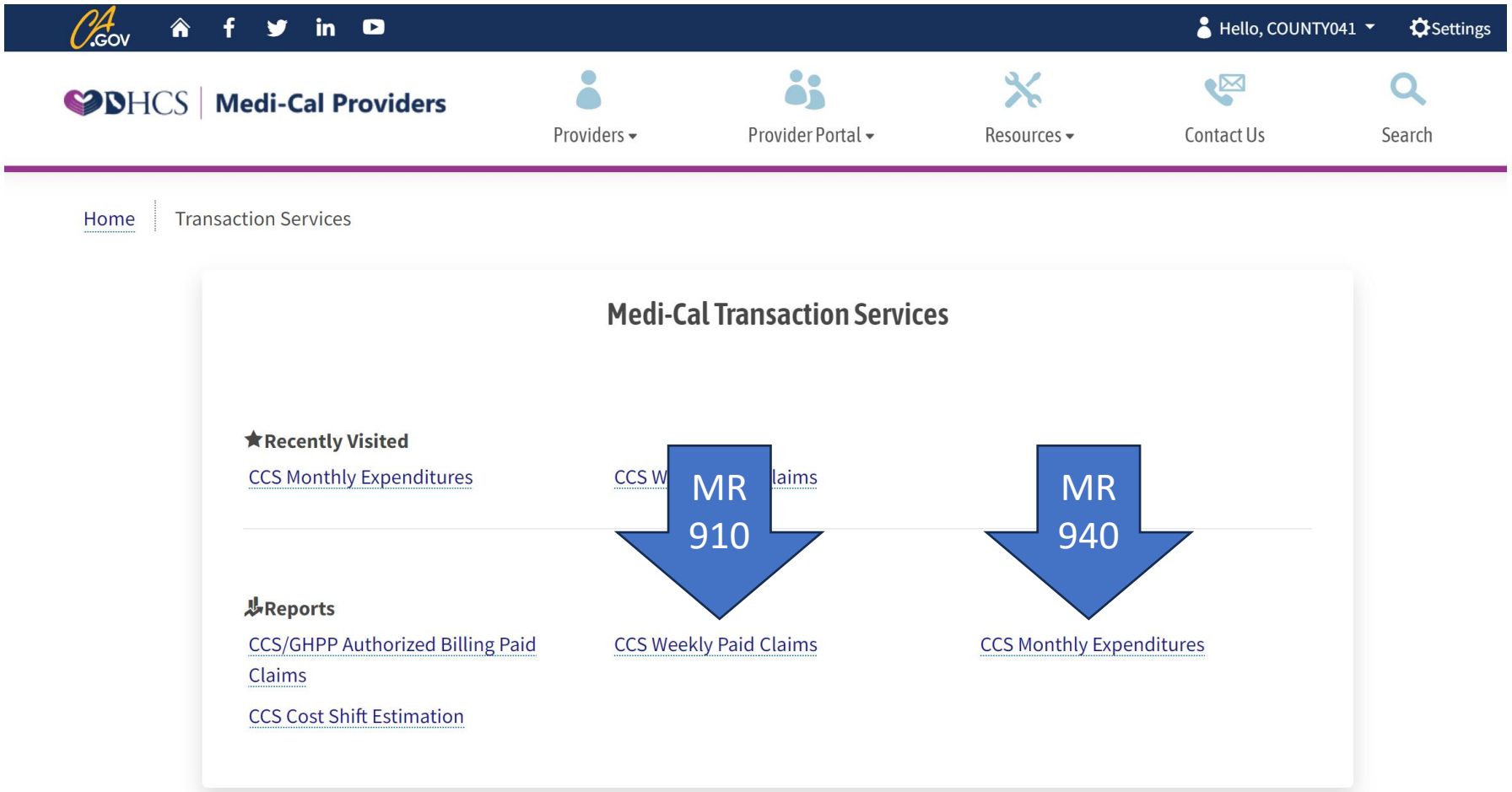
2. Which of the following can result in an MTC claim being denied? (More than one correct answer)
   - Incorrect use of a decimal point
   - Forgetting to stamp the form with the CCS County Stamp
   - Using a copy of a claim form instead of an original claim form

Part VI – MR-O-910 & MR-O-940s

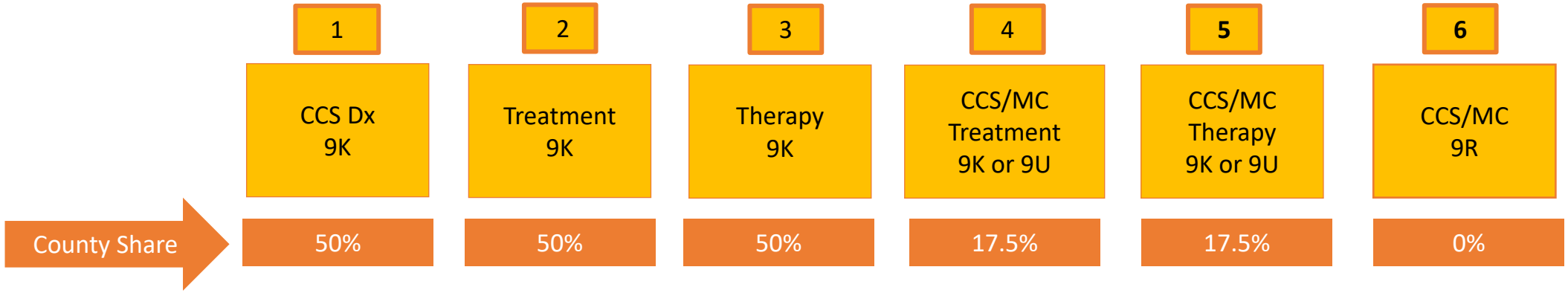
Purpose of MR940/10 Reports

- Provides a way for counties to track claims paid with county funds and claims paid for Medical Therapy Conference
- Counties can check this report to find claims that should not have been paid with county funds
- Provides a way to check that automatic corrections to those errors are made
- Used for completing the Quarterly Tx/Dx/Therapy Invoice and the Quarterly OTLICP Invoice.

Where to find the MRO-910 and 940 Reports:



Six Different Funding Categories



Eligible Cost Shifts - Submit Paper Correction

- From funding categories 4 or 5 to funding category 6

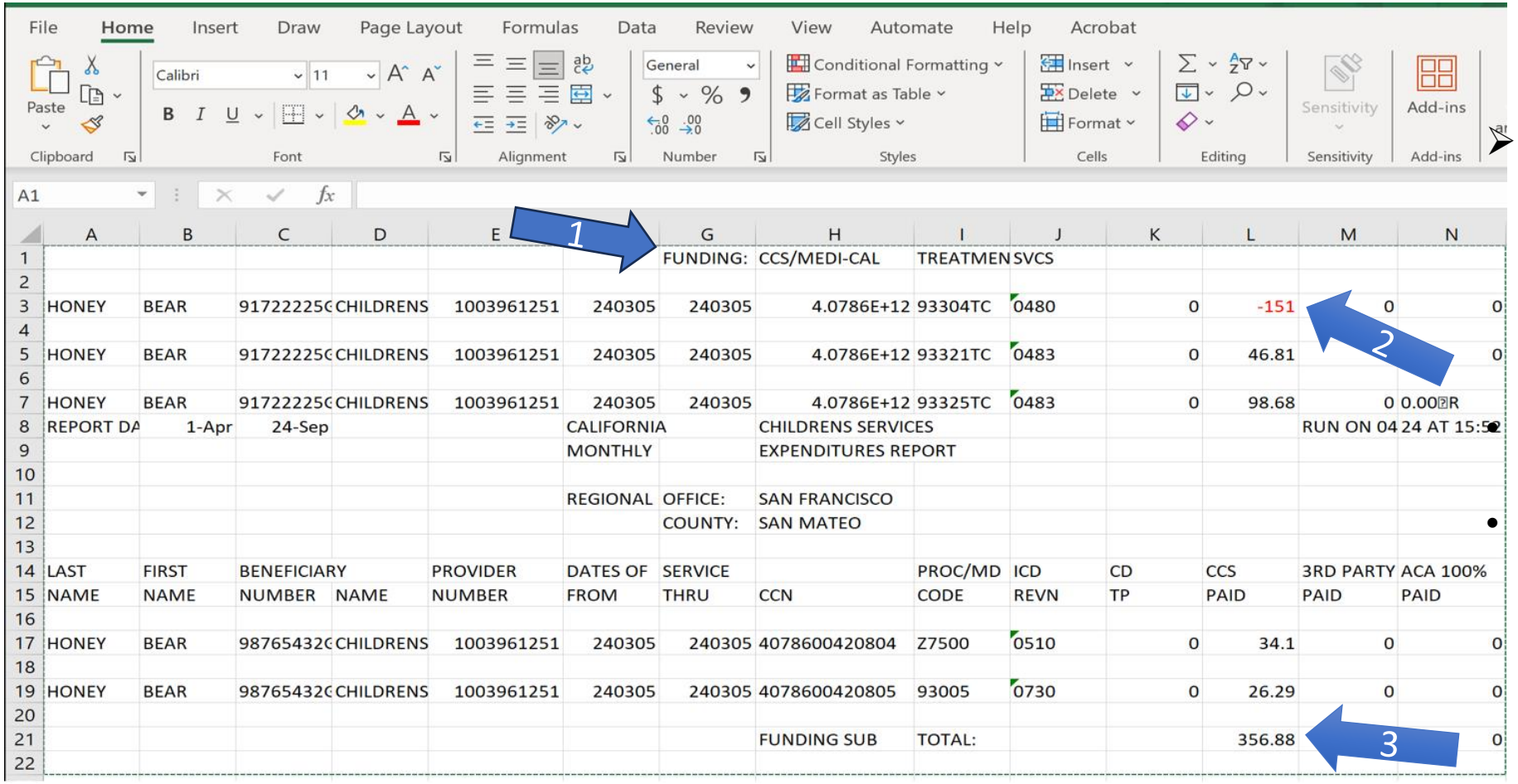
Automatic Cost Shifts - Do not submit Paper Correction

- From funding categories 1, 2, or 3 to any other category
- From any funding category to full scope Medi-Cal
- This is completed by a biannual process integrated into the Payment System. Replacing the electronic Payment Correction EPC

Cost Sharing Percentages

- Diagnostic Services (CCS aid code 9K, 50% county share).
- Treatment Services (CCS aid code 9K, 50% county share).
- Therapy Services (CCS aid code 9K, 50% county share)
- CCS Program/Medi-Cal Treatment Services Optional Targeted Low income Children's Program (OTLICP) aid codes T1, T2, T3, T4, T5, and the (CCS Program aid code 9K or 9U,50% County Share)
- CCS Program/Medi-Cal Therapy Services (OTLICP aid codes T1, T2, T3, T4, T5, and the (CCS Program aid code 9K or 9U,50% County Share)
- Medi-Cal Services (OTLICP aid codes T1, T2, T3, T4, T5, and the (CCS Program aid code 9R, 0% county share)

MR 940 Sample Report



	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1							FUNDING:	CCS/MEDI-CAL	TREATMEN	SVCS				
2														
3	HONEY	BEAR	91722225(	CHILDRENS	1003961251	240305	240305	4.0786E+12	93304TC	0480	0	-151	0	0
4														
5	HONEY	BEAR	91722225(	CHILDRENS	1003961251	240305	240305	4.0786E+12	93321TC	0483	0	46.81	0	0
6														
7	HONEY	BEAR	91722225(	CHILDRENS	1003961251	240305	240305	4.0786E+12	93325TC	0483	0	98.68	0	0.00R
8	REPORT DA	1-Apr	24-Sep			CALIFORNIA		CHILDRENS SERVICES					RUN ON 04	24 AT 15:5
9						MONTHLY		EXPENDITURES REPORT						
10														
11						REGIONAL	OFFICE:	SAN FRANCISCO						
12							COUNTY:	SAN MATEO						
13														
14	LAST	FIRST	BENEFICIARY		PROVIDER	DATES OF	SERVICE		PROC/MD	ICD	CD	CCS	3RD PARTY	ACA 100%
15	NAME	NAME	NUMBER	NAME	NUMBER	FROM	THRU	CCN	CODE	REVN	TP	PAID	PAID	PAID
16														
17	HONEY	BEAR	98765432(	CHILDRENS	1003961251	240305	240305	4078600420804	Z7500	0510	0	34.1	0	0
18														
19	HONEY	BEAR	98765432(	CHILDRENS	1003961251	240305	240305	4078600420805	93005	0730	0	26.29	0	0
20														
21								FUNDING SUB	TOTAL:			356.88		0
22														

Instructions on how to download the Report can be found in the Tool Kit.

Positive Charge (+) indicates a Debit
Negative Charge(-) indicates a Credit

Manual Correction Sample

- Paper Form Should be used for allowable Cost Shift Requests
- This Form is in CCS-IN-19-06, however this IN is currently under revision

ATTACHMENT A
REPORT TO CORRECT MR-O-940 ERRORS

To: Integrated Systems of Care Division
Department of Health Care Services
Email: ISCDFiscal@dhcs.ca.gov
Fax: (916) 440-5769

Sample

Date: 12/25/2023

Report Run Date: 04/24/2024

From: Martha Alexander

Re: California Children's Services (CCS) Program
Correction of Error(s) on MR-O-940 Reports

Fund Code: (1) CCS DX SERVICES; (2) CCS TR SERVICES; (3) CCS TH=THERAPY SERVICES; (4) CCS/MED TR SERVICES; (5) CCS/MED TH; (6) CCS/MEDI-CAL

					Charged in Error		Correct Charge	
Name of Child	Date of Birth	CCS#	Date(s) of Service	Amount	Fund Code	County	Fund Code	County
Honey, Bear	12/25/2024	1234567	240305	$ 34.1	4	San Mateo	6	San Mateo

Total Amount to be Adjusted: $ 34.1

Comments: Client has CCS aid code 9 and billed as 9K please make correction

The expenditures identified above were charged in error. Please make the appropriate adjustments to show these expenditures in the correct fund code and county.

County Signature: Martha Alexander Date: 07/14/2024 Email: Malexander@smcgov.org

Title: Benefits Analyst Telephone number: 650-616-2504

Highlights

- CCS N.L CCS IN 19-06 (ca.gov) effective 10/7/2019 is currently under revision
- No Action needed to shift costs to Medi-Cal for a Beneficiary with a regular Medi-Cal Aid code (e.g. 60, 83)
- Biannual process integrated in the payment system that identifies and corrects claims where the funding cannot be shifted. Similar to the previous Electronic Payment Correction (EPC) process.
- Requests for adjustment of $100 or less may not be processed
- Staff assigned to complete varies from County to County. Most common assignment is for Fiscal or Administrative staff.
- Pharmacy claims are not on the MR-940/910. The State is working on a new report so that counties can have claim level detail on pharmacy claims that have county cost sharing

Part VII - Resource

Key Resources for Claims and Billing Information

Part VII – Resources

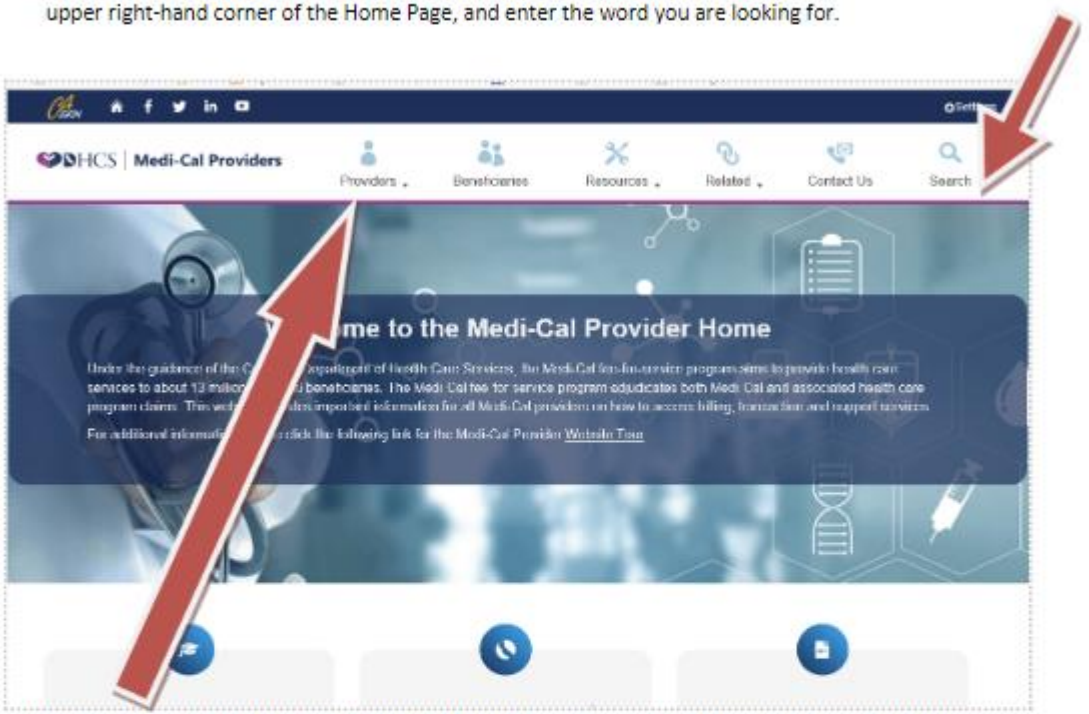
Searching Online for Answers	
Numbered Letters and Information Notices	Information Notices and Numbered Letters are used by DHCS to push out updated information. This is the first place to look for information on changes on any business-related process and products. It will be helpful to become familiar with this page and the information contained in it.
This Computes!	This Computes are a valuable source of information to help in determining a product or service use. They are no longer published by DHCS, but an archive can be found in CMSNet. **How to Locate:** From the CMSNet home page, locate Bulletins in the top right corner. Open Bulletins and you will find a link to the Archive. This is an excellent place to begin looking for both creating SARs and finding problem resolutions.
Medi-Cal Outreach and Education Portal	The Medi-Cal learning portal offers online recorded and live trainings about Medi-Cal billing basics, CCS overview, policies, and procedures.
Service Now Portal	The preferred method to contacting the CMS Net Help desk is by submitting a ticket through the Service Now portal for account maintenance, CMSNet service requests, and to upload PTRs. Contact your local County Administrator-Plus to get set up with an account. Login to CMSNet and scroll down to the bottom to determine your local County Systems Administrators.

1. **Numbered Letters & Information Notices**: Updates from DHCS on business processes.
2. **This Computes!**: Archived resource in CMSNet for product/service usage.
3. **Locating Resources**:
    1. **CMSNet Legacy**: Access Bulletins via the top right corner.
    2. **CMS2020**: Find Bulletins under the Trainings section.
4. **Medi-Cal Outreach & Education Portal**: Online training on Medi-Cal billing and policies.
5. **Service Now Portal**: Submit tickets for CMS Net Help Desk assistance.
6. **MSBI Claims Reports**: Standard and custom report requests available via Service Now.
7. **Medi-Cal Reimbursement Rates**: Look up provider rates by CPT code.
8. **CRISS Website**: Access documents related to claims topics for CCS counties.

Medi-Cal Website

Medi-Cal Website

The Medi-Cal website is an important place to search for up to date information for all things related to CCS billing. To search for information on a specific keyword or code, click on "Search Medi-Cal" in the upper right-hand corner of the Home Page, and enter the word you are looking for.



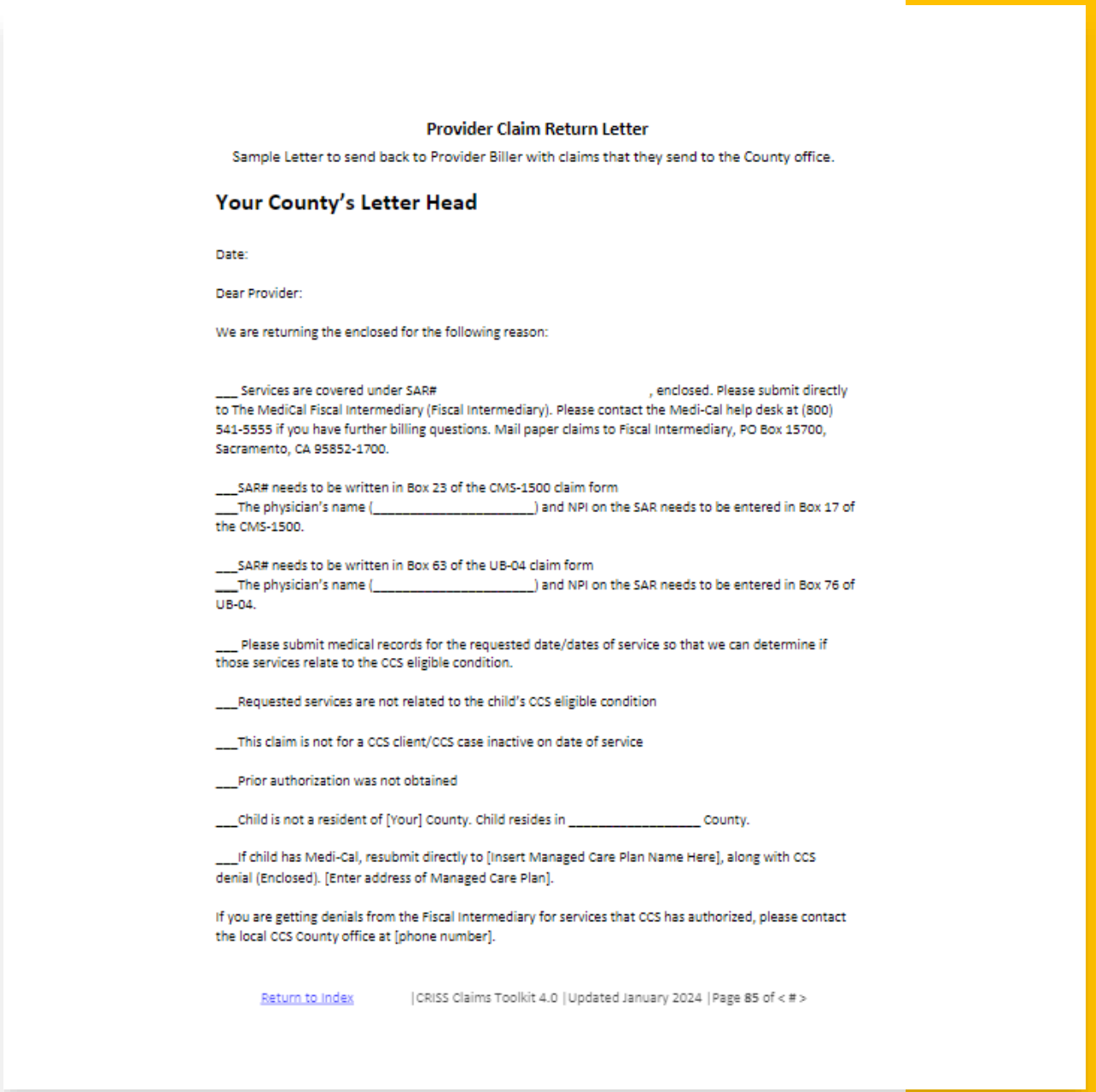
Or, you can search the Provider Manuals in listings by clicking on Providers, and then "Publications".

Tips for using the Medi-Cal search engine:

- Less information works best
- Throughout this toolkit, the best tried and tested search phrases are written in the left side column

What to do when an issue requires more than online research?	
Contact the CCS Field Representative at the Fiscal Intermediary, or	To find the rep for your region, contact the Telephone Service Center at 1-800-541-5555. Let them know you are requesting a Field Rep for assistance. Your rep will contact you in 1 –2 business days.
Contact the CRISS Claims Workgroup representative from the Fiscal Intermediary	Current Contact as of the date of this publication (9/2024): Shalena Wardell Swardell2@gainwelltechnologies.com

Provider Claim Return Letter



Provider Claim Return Letter

Sample Letter to send back to Provider Biller with claims that they send to the County office.

Your County's Letter Head

Date:

Dear Provider:

We are returning the enclosed for the following reason:

___ Services are covered under SAR# , enclosed. Please submit directly to The MediCal Fiscal Intermediary (Fiscal Intermediary). Please contact the Medi-Cal help desk at (800) 541-5555 if you have further billing questions. Mail paper claims to Fiscal Intermediary, PO Box 15700, Sacramento, CA 95852-1700.

___SAR# needs to be written in Box 23 of the CMS-1500 claim form
___The physician's name (_____) and NPI on the SAR needs to be entered in Box 17 of the CMS-1500.

___SAR# needs to be written in Box 63 of the UB-04 claim form
___The physician's name (_____) and NPI on the SAR needs to be entered in Box 76 of UB-04.

___ Please submit medical records for the requested date/dates of service so that we can determine if those services relate to the CCS eligible condition.

___Requested services are not related to the child's CCS eligible condition

___This claim is not for a CCS client/CCS case inactive on date of service

___Prior authorization was not obtained

___Child is not a resident of [Your] County. Child resides in _____ County.

___If child has Medi-Cal, resubmit directly to [Insert Managed Care Plan Name Here], along with CCS denial (Enclosed). [Enter address of Managed Care Plan].

If you are getting denials from the Fiscal Intermediary for services that CCS has authorized, please contact the local CCS County office at [phone number].

Glossary of CCS Jargon

Commonly Used Jargon in the Billing World

A guide to acronyms for CCS staff assisting providers with denials.

ACSNET – The electronic information system for Medi-Cal fee-for-service claims. Also known as CA-MMIS

Adjudicate - to make a decision on a claim or a Service Authorization Request

BIC – Benefits Identification Card. This is the ID card that the Department of Social Services mails to the client when they are awarded Medi-Cal or CCS. Client presents this card at the provider office or pharmacy as proof of benefits.

CAL POS – California Point of Service. This is the system providers can use to submit electronic claims to Fiscal Intermediary.

CA-MMIS – California Medicaid Management Information System (see ACSNet)

Capitated - A way of paying health care providers or organizations in which they receive a predictable, upfront, set amount of money to cover the predicted cost of all or some of the health care services for a specific patient over a certain period of time.

CCN – Claim Control Number. This is an 11 digit reference number associated with each claim. It is printed on the Remittance Advice Details (RAD) or can be acquired in CalPOS. Handy when contacting the Telephone Service Center (TSC) to get more information on a denied claim.

CIF – Claims Inquiry Form. This is used to request an adjustment for either an underpaid or overpaid claim, request a Share of Cost (SOC) reimbursement or request reconsideration of a denied claim. For more information refer to Medi-Cal Publications CIF Completion and CIF Submission and Timeliness Instructions.

CIN—Client Index Number. This is the unique 9-digit Medi-Cal ID number given to each recipient.

CMC—Computer Media Claims. Claims that are submitted electronically.

CMS-1500 – Commonly used claim form for submitting claims to Fiscal Intermediary. The other is the UB-04, or the Pharmacy 30-1.

COS – Category of Service. If a provider is not eligible for the appropriate category of service, a claim may deny for this reason.

CPT-4 – Physicians' Current Procedural Terminology. Five-digit code entered on claim form to identify the service being billed. CPTs are a Level I HCPCS code, and are numeric.

DHCS – Department of Health Care Services.

DRG – Diagnosis Related Groups. A system of classifying any inpatient stay into groups for the purposes

Knowledge Check

Knowledge Check Answers

1. What is the minimum amount allowed to be submitted for correction?
    - $100
2. How many funding categories are there?
    - 6
3. Where can ThisComputes be located?
    a. On CMSNet legacy, by clicking on Bulletins from the homepage
    c. On CMS2020, by clicking on Trainings and scrolling to the bottom of the Bulletins section
    e. Both A and C

Thank you for attending the CCS CRISS Claims Toolkit Webinar.
The recording and powerpoint will be available on the
CRISS website:
https://www.criss-ca.org/