KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Claims Submission and Reimbursement				POLICY #: 6.01-P	
DEPARTMENT: Claims					
Effective Date: 08/2000	Review/Revised Date: June 8, 2022	DMHC	X	PAC	
		DHCS	X	QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Emily Duran
Chief Executive Officer

_____ Date _____
Chief Financial Officer

_____ Date _____
Chief Operating Officer

_____ Date _____
Director of Compliance and Regulatory Affairs

_____ Date _____
Director of Claims

POLICY:
Kern Health System (KHS) guidelines for claims submission shall be communicated to KHS contracted providers, and to non-contracted providers upon request, to provide for timely and accurate claims submission and reimbursement.

KHS shall reimburse 90% of clean claims from providers who are in individual or group practices or who practice in shared health facilities, within 30 calendar days of the date of receipt and 99% of all clean claims within 90 days. KHS shall reimburse each completed claim, or portion thereof, as soon as possible, but no later than 45 working days after the date of receipt of the complete claim. In accordance with State regulations, KHS will pay interest on clean claims not paid within 45 working days of receipt[1]. See 1.1, 1.1.1 and 1.1.2. The date of receipt shall be the date KHS receives the claim, as indicted by its date stamp on the claim. The date of payment shall be the date of the check

or the form of payment.

The KHS Claims Department (Claims) will make every effort to identify members that are covered under any other State or Federal Medical Care Program or under other contracted or legal entitlement including, but not limited to, a private group or indemnification program. Claims staff will make every effort to recover any monies paid for services provided to members prior to identifying such other coverage.

Claims will identify cases which involve Casualty Insurance, Tort Liability, or Workers' Compensation. KHS will notify the Department of Health Care Services (DHCS) or its designated contractor of all such cases involving Medi-Cal Product members.

- Claims will be processed in accordance with the statutory, regulatory, and contractual requirements outlined in the following sources: California Health and Safety Code §1371, 1371.35, 1371.36, 1371.37, and 1371.39
- CCR Title 28 §1300.71, 1300.71.38; and 1300.77.4

DEFINITIONS:

Information necessary to determine payer liability[2]	The minimum amount of material information in the possession of third parties related to a provider's billed services that is required by a claims adjudicator or other individuals with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost if applicable, and extent of the plan's liability, if any, and to comply with governmental information requirements.
Reasonably relevant information[3]	The minimum amount of itemized, accurate and material information generated by or in the possession of the provider related to the billed services that enables a claims adjudicator with appropriate training, experience, and competence in timely and accurate claims processing to determine the nature, cost, if applicable, and extent of the plan's liability, if any, and to comply with governmental information requirements.
Working Days[4]	Monday through Friday, excluding recognized federal holidays. Recognized federal holidays are as follows[5]: A. New Year's Day: closest weekday to January 1st B. ML King's Birthday: 3rd Monday in January C. Washington's Birthday: 3rd Monday in February (aka Presidents' Day) D. Memorial Day: last Monday in May E. Juneteenth: closest weekday to 6/19 F. Independence Day: closest weekday to July 4th G. Labor Day: 1st Monday in September H. Columbus Day: 2nd Monday in October I. Veteran's Day: Closest weekday to November 11th (aka Armistice Day)

	J. Thanksgiving Day: 4th Thursday in November K. Christmas Day: Closest weekday to December 25th

PROCEDURES:

1.0 CLAIMS SUBMISSION

The preferred method of claim submission is Electronic billing. Electronic billing may be used to bill KHS for any claims that do not require an attachment. All electronic transactions with KHS must be HIPAA compliant. Providers utilizing electronic billing should submit electronic claims through Change Healthcare (Emdeon, Relay Health), Cognizant, SSI, or Office Ally. Providers requiring assistance in submitting electronic claims through any of the clearinghouses listed above, should contact the KHS Provider Relations Department.

Should an attachment be required for claim submissions, such as PM330, Invoice pricing, requested records; Claims should be mailed to the following address:

Claims Department
Kern Health Systems
PO Box 85000
Bakersfield, CA 93380

KHS prohibits providers from using members Social Security Numbers (SSN) on claims submitted for reimbursement[6]. Providers shall use the member Client Identification Number (CIN) or the KHS Member Identification Number when submitting claims to reduce the fraudulent use of SSNs in the Medi-Cal program.

Hospitals, long term care facilities, licensed primary care clinics and emergency medical transportation are excluded from the SSN billing restriction. However, these excluded entities are required to make a good faith effort to obtain the member's CIN information for billing.

Providers shall restrict the use of the member's SSN whenever possible, especially as an identifier in the processing of claims.

1.1 Deadlines

Claims received after 3:00 PM are opened and scanned as received the following day. Claims submission deadlines for contracted and non-contracted providers differ as described below. Providers may submit a provider dispute regarding a claim that was denied as a late submission. If good cause for the delay is demonstrated, the 180 calendar day deadline will be waived, and the claim adjudicated as if it was submitted within 180 calendar days following the provision of covered services.[7]

1.1.1 Contracted Providers

In order to receive full compensation, contracted providers should submit to KHS a complete, written bill for all covered services rendered within one hundred and eighty (180) calendar days

following the provision of the covered services.

Claims received after 180 calendar days[8] following the provision of the covered services are denied with the following exceptions:

A. Other Primary Insurance: Claims submitted within 90 calendar days[9] of the date of the primary carrier's Explanation of Benefits (EOB). Any such claims received after the 90 calendar day deadline and are also beyond 180 calendar days are denied.
B. California Children's Services: Claims must be submitted within 90 calendar day s of the CCS denial letter. Any such claims received after the 90 calendar day deadline and are also beyond 180 calendar days are denied.

1.1.2 Non-Contracted Providers

Claims received after six (6) months[10] following the provision of the covered services are denied with the following exceptions:

A. Failure of the patient to identify himself or herself as a Medi-Cal beneficiary within four months after the month of service.
B. If a provider has submitted a bill to a liable third party, the provider has one year after the month of service to submit the bill for payment.
C. If a legal proceeding has commenced in which the provider is attempting to obtain payment from a third party, the provider has one year to submit the bill after the month in which the services have been rendered.
D. The director finds that the delay in submission of the bill was caused by circumstances beyond the control of the provider.
E. Other Primary Insurance: Claims submitted within 90 calendar days[11] of the date of the primary carrier's Explanation of Benefits (EOB). Any such claims received after the 90 calendar day deadline and are also beyond six (6) months are denied.
F. California Children's Services: Claims submitted within 90 calendar days of the CCS denial letter. Any such claims received after the 90 calendar day deadline and are also beyond six (6) months are denied.

All non-emergency services by non-contracted providers, except for STD and family planning services require prior authorization. See *KHS Policies and Procedures #3.21 Family Planning Services and #3.17 STD Treatment.*

1.2 Format for Paper Submissions

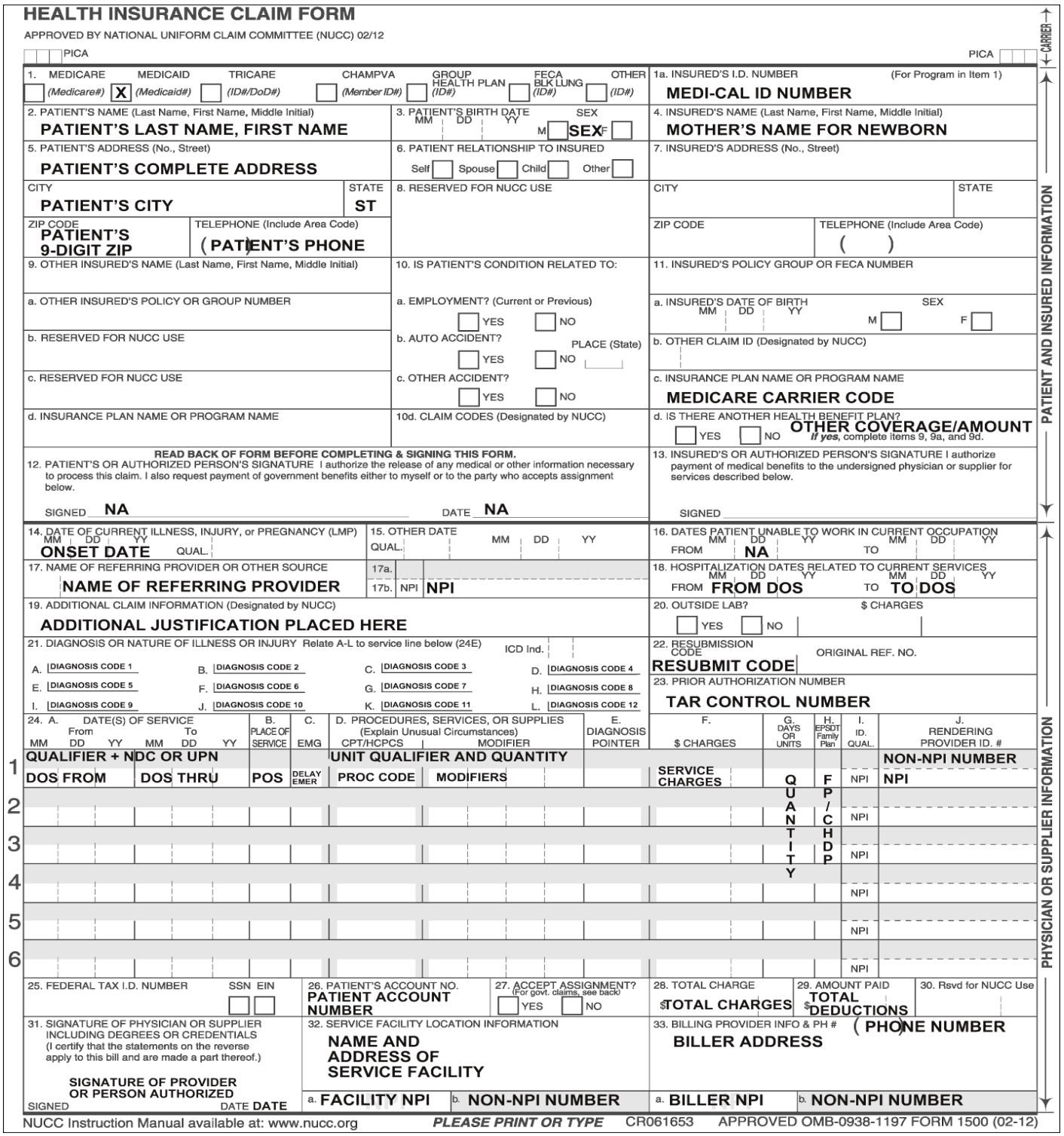
Appropriate claim forms or electronic data formats should be used. The red

Health Insurance Claim Form (CMS 1500) with sensor block must be used to bill for professional/supplier services. It should be used by physicians, laboratories, and allied health professionals to submit claims for medical services. Durable medical equipment and blood products should also be billed using this form. Pharmacies may also use this form to bill for supplies not billable through the on-line pharmacy claims processing service.

The red *UB-04* Claim Form should be used to submit claims for inpatient Hospital accommodations and ancillary charges and for hospital outpatient services.

1.3 Content

The billed amount should be based on the same fee schedule used to bill other third party payers. Any copayment or coordination of benefits (COB) payments collected should be indicated in the appropriate data field of the claim. Providers should follow the Medi-Cal instructions for completing the *CMS 1500* and *UB-04* Forms, with the exception of Box 24J as indicated on page 7 of this policy. This includes the use of an alternative member identification number in lieu of the member's SSN[12]. KHS prohibits any use of the member's SSN when filing claims to KHS for KHS reimbursement. Paper claims will be denied, and EDI claims will be rejected.



HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

1. MEDICARE (Medicare#) | MEDICAID [X] (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): MEDI-CAL ID NUMBER

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

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

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. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE: PATIENT'S 9-DIGIT 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. 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: MEDICARE CARRIER CODE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

PATIENT AND INSURED INFORMATION

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

15. OTHER DATE QUAL. MM DD YY

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

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 MM DD YY TO TO DOS

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ADDITIONAL JUSTIFICATION PLACED HERE

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. DIAGNOSIS CODE 1 B. DIAGNOSIS CODE 2 C. DIAGNOSIS CODE 3 D. DIAGNOSIS CODE 4

E. DIAGNOSIS CODE 5 F. DIAGNOSIS CODE 6 G. DIAGNOSIS CODE 7 H. DIAGNOSIS CODE 8

I. DIAGNOSIS CODE 9 J. DIAGNOSIS CODE 10 K. DIAGNOSIS CODE 11 L. DIAGNOSIS CODE 12

22. 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	QUALIFIER + NDC OR UPN / DOS FROM / DOS THRU	POS	DELAY EMER	UNIT QUALIFIER AND QUANTITY / PROC CODE	MODIFIERS		SERVICE CHARGES	QUANTITY	FP/CHDP	NPI	NON-NPI NUMBER / NPI
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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. 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.)

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 #: (PHONE NUMBER BILLER ADDRESS

a. BILLER NPI b. NON-NPI NUMBER

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

Submitted claims must include a full itemization of charges and the following information:

Information	CMS 1500 Box	UB92 Box
Patient's KHS identification number or CIN (not SSN)	1a	60
Patient's name	2	8b
Patient's date of birth	3	10
Patient's home address	5	9a-e
Other insurance coverage, including Medicare (if applicable)	11a-d	50a, 58a, 59a, 60a, 61a, and/or 62a
Rendering/Ordering NPI number	17b	76
Diagnosis Code	21	66a-q **DIAGNOSIS CODE HEADER.** For claims with dates of service/dates of discharge on or after October 1, 2015, enter the ICD indicator "0" in the white space below the *Diagnosis Code* field (Box 66). No ICD indicator is required if the claim is submitted without a diagnosis code.
ICD Indicator 9 or 0	21 ICD ind.	
Resubmission code (claim Frequency Code) 1 for an original encounter submission, 7 for a replacement submission (note replacement will replace the full previous claim)	22	
KHS Authorization Number (if applicable)	23	63a
Date of service, Place of service	24a, 24b	6, 12 and 45
CPT/HCPCS Code (including appropriate modifier), Medi-Cal defined codes	24d	42, 44
Diagnosis Pointer	24E	NA
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).	24F	47

If an item is a taxable medical supply, include the applicable state and county sales tax.		
Days or Units	24G	46
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: Acupuncturist Physicians Chiropractors Podiatrists Licensed audiologists Portable X-ray providers Occupational therapists Prosthetists Ophthalmologists Psychologists Orthopedists Radiology labs Physical therapists Speech pathologists Physician groups	24J	76
Vendor Federal tax identification number	25	5
Total Charge	28	47 line 23
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.	31	NA
INFORMATION. Enter the provider's 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	32	NA
Enter the NPI of the facility where the services were rendered.	32A	NA
Billing Provider Information and Phone Number	33	NA
Entering the billing provider's NPI	33A56	
	33a	1
	24J	56

For further clarification refer to the Medi-Cal Manual

1.3.1 Unbundling

KHS requires procedure codes to be bundled as outlined in the *American Medical Association Current Procedural Terminology (CPT) Guidebook*. Providers will not be reimbursed more for performing

portions of a bundled group than they would be reimbursed for performing the complete group.

KHS uses a code auditing tool to assist claims processors in identifying claims that are potentially unbundled. Information regarding unbundling policies for specific CPT or HCPCS procedure codes may be obtained by submitting a written request to the Claims Department or calling the Claims Department at 1-800-391-2000.

1.4 Supporting Documentation

Claims are processed according to the guidelines listed in the table below.

Procedure Code or Claim Type	Description / Explanation	Restriction/Requirement
Ambulance services	See *KHS Policy and Procedure #3.50 – Ambulance Transportation Services* for details.	For Non-participating providers a trip sheet is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation.
By report procedures		Narrative Medical Summary is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation. Invoice for supplies.
DME	Items that do not have established Medi-Cal rates	Invoice is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation. Invoice for supplies.
Other insurance primary	Includes Medicare See KHS Policy *#6.08 - Coordination of Benefits*	EOB from primary insurance is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation. Note: Electronic claim submission requires appropriate fields completed. Actual EOB is not required for electronic claims.
Sterilization	See *KHS Policy #2.19 – Sterilization Consent* for details.	Sterilization consent form is required. Claims received without the necessary documentation are denied. Claims may be resubmitted with required documentation.

Procedure Code or Claim Type	Description / Explanation	Restriction/Requirement
Surgical procedures		By Report Surgical procedures, need to be submitted with necessary documentation or they will be denied. Claims may be resubmitted with required documentation.
99284	Non-Contracted Providers only. Emergency Department visit (detailed history, detailed examination, and medical decision making of moderate complexity)	Medical review of ER report may be required. Claims received without the report are reimbursed at the 99283 level, if a report is necessary.
99285	Non-Contracted Providers only. Emergency Department visit (comprehensive history, comprehensive examination, and medical decision making of high complexity)	Medical review of ER report may be required. Claims received without the report are reimbursed at the 99283 level, if a report is necessary.

2.0 MISDIRECTED CLAIMS

Claims involving Emergency Services shall be forwarded to the appropriate payer within 10 working days of receipt of the claim.

Claims not involving Emergency Services:

- If the provider that filed the claim is contracted with the plan's capitated provider, the Plan has 10 working days of the receipt of the claim to: Send the claimant a notice of denial, with instructions to bill the capitated provider, or forward the claim to the appropriate capitated provider.
- In all other cases, the plan has 10 working days of the receipt of the claim incorrectly sent to the plan to forward the claim to the appropriate payer.

3.0 ER SERVICES

KHS will reimburse all medically necessary emergency claims according to the eligibility of the member at the time of service. KHS will not provide payment for services unless the clinical situation causing the patient to present to the facility is a life threatening emergency. At a minimum, reimbursement for an MSE is made to all emergency room providers, (professional and facility component and hospital based urgent care facilities). See *KHS Policy and Procedure #3.31 Emergency Services*

Section 5.0.

4.0 CLAIMS RESUBMISSION

Claims may be resubmitted for reprocessing within 45 business days of the date of payment/denial. Claims resubmitted after the 45 business day deadline are denied.

Simple resubmission of a claim does not initiate the provider dispute process. To initiate the dispute process, providers must follow the procedure outlined in *KHS Policy and Procedure #6.04 – Practitioner/Provider Disputes Regarding Claims Payment*.

5.0 REIMBURSEMENT

KHS reimburses contracted providers based on the compensation agreement specified in their contract**.** KHS rates are based on the Medi-Cal fee schedule identified in the applicable provider contract. Providers may view an electronic fee schedule at www.medi-cal.ca.gov. Case rates and per diem rates are stipulated in the provider contract. Non-Contracted providers are reimbursed at Medi-Cal rates.

5.1 Emergency Services & Urgent Care

If the group or site is PAR and the attending provider is Non PAR, reimbursement is at the group/site contract rate.

If the group or site is Non PAR and the attending provider is Non PAR, reimbursement is at Medi-Cal rates.

5.2 PT/OT/ST, Lab, Pathology & Radiology Services

If the group or site is PAR and the attending provider is Non-PAR, if Non-PAR provider is authorized reimbursement is at Medi-Cal rates otherwise claim is denied.

5.3 Hospitalist Providers

If the group or site is PAR and the attending provider in Non PAR, reimbursement is at the Medi-Cal rate.

If the group or site is Non PAR and the attending provider is Non PAR, reimbursement is at the Medi-Cal rate.

If the group or site is PAR and the attending provider is PAR reimbursement is at the contract rate.

Additional reimbursement guidelines are contained in the following KHS policies:

A. *KHS Policy and Procedure #3.05-P: Preventive Medical Care*
B. KHS Policy and Procedure #3.12 – Urgent Care Services
C. *KHS Policy and Procedure #3.23-P: Emergency Services*
D. KHS Policy and Procedure #3.24-P: Pregnancy and Maternity Care
E. KHS Policy and Procedure #3.46 – Tuberculosis Treatment
F. *KHS Policy and Procedure #6.09-P: Assistant Surgeon*
G. *KHS Policy and Procedure #6.18 – Laboratory Billing Guidelines and*

Restrictions

H. *KHS Policy and Procedure #6.19 – DME Billing Guidelines*
I. *KHS Policy and Procedure #6.21 – Infusion Billing Guidelines*

KHS uses Medi-Cal billing criteria unless otherwise specified in a KHS policy. The Medi-Cal Provider Manual is available online at www.medi-cal.gov. The Medi-Cal Provider Manual includes but is not limited to the following:

A. Policies and procedures which provide detailed payment policies and rules and non-standard coding methodologies used to adjudicate claims. These documents clearly and accurately describe all global payment provisions[13]
B. Information regarding reimbursement for the administration of injectable medications
C. Policy regarding consolidation of multiple services or charges and payment adjustment due to coding changes
D. Policy regarding reimbursement for multiple procedures
E. Policy regarding recognition of CPT modifiers

Complete claims or portions thereof are reimbursed or denied within 45 working days of receipt.[14] Only members for whom a premium is paid by the State to KHS are entitled to health services and benefits provided hereunder and only for services rendered or supplies received during the period for which the member is enrolled.[15]

As stated in the provider contract, except for applicable copayments, providers may not invoice or balance bill KHS members for the difference between billed charges and the reimbursement paid by KHS for any covered benefit.[16]

5.4 Coordination of Benefits and Third Party Liability

If the member has other medical coverage, the provider must file the claim with the other primary insurance carrier before filing with KHS. Upon receipt of partial payment or denial from the other carrier, the provider should submit the claim to KHS along with documentation of payment or denial from the primary carrier. The Claims Department requires a copy of the other Plan's payment determination prior to releasing payment for those members covered by another Plan.

KHS secondary payment for eligible services is limited to the maximum that KHS would compensate providers as specified in the provider's contract. The primary and secondary payments may not add up to more than 100% of eligible charges.

KHS does not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates either third party coverage, designated by the Other Health Coverage (OHC) code, or Medicare coverage without proof that the provider has first exhausted all other sources of payment. An exception to this guideline exists for services and OHC codes which request post-payment recovery. Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y or Z.

The Claims Department does not attempt recovery in circumstances involving Casualty Insurance, Tort Liability, or Workers' Compensation awards to Medi-Cal members. Circumstances which may result in Casualty Insurance payments, Tort Liability payments, or Worker's Compensation awards are reported, in writing, to DHCS as appropriate within 10 (ten) calendar days after discovery by KHS.

6.0 MODIFERS

6.1 25 Significant, Separately Identifiable E&M Service Description

This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc.…)

CPT modifier -25 is used when, on the day a procedure or service was performed, the patient's condition required a significant, separately identifiable evaluation and management (E&M) service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.

Policy Statement

KHS does not deny payment for CPT evaluation and management (E&M) codes with a CPT modifier -25 appended when submitted with surgical or other procedure codes for the same patient on the same date of service based solely on the existence of the modifier -25.

The submission of modifier -25 appended to an E&M code indicates that documentation is available in the patient's records for review upon request that will support the significant and separately identifiable nature of the E&M service.

All surgical procedures and some procedural services include a certain degree of physician involvement or supervision which is integral to that service. For those procedures and services, a separate E&M service is not normally reimbursed. However, a separate E&M service may be considered for reimbursement if the patient's condition required services above and beyond the usual care associated with the procedure or service provided. To identify these circumstances, modifier -25 is attached to the E&M code.

<u>Example of Proper Use of Modifier -25</u>

An established patient is seen for a 2.0cm finger laceration. The patient also asks the physician to evaluate swelling of his right knee that is causing pain.
Correct Codes – 12001 and 99213-25

<u>Example of Improper Use of Modifier -25</u>

An established patient is seen for left knee pain. After evaluating the knee, the physician performs arthrocentesis.
Correct Code – 20610
It would not be appropriate to bill an E&M code because the focus of the visit was the knee pain which precipitated the arthrocentesis.

Multiple E&M Services

Only one E&M service code per patient, per physician, per day is eligible for reimbursement unless:

- the visits were for unrelated problems that could not be provided during the same encounter (i.e., scheduled office visit in the morning for ear pain and 4 hours later an unscheduled visit for a broken wrist).

In this cases, modifier -25 should be attached to the E&M codes.

References

American Medical Association. "Appendix A: Modifiers". Current Procedural Terminology (CPT). Chicago: AMA Press. 2008.

NCCI Policy Manual for Medicare Services, current version Chapter 1.

6.2 53; Discontinued Procedure

Definitions

This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc. see modifier 73 & 74)

CPT Modifier -53 is appended to a code when a physician elects to terminate a surgical or diagnostic procedure due to extenuating circumstances.

Policy Statement

CPT Modifier -53 is valid only when a physician elects to terminate a surgical or diagnostic procedure due to extenuating circumstances that threaten the wellbeing of the patient.

Modifier -53 is eligible to attach to one code per operative session.

When modifier -53 is valid, the discontinued procedure may be reimbursed at a rate reduced from the usual allowable for the procedure.

Modifier -53 is not valid when used for elective cancellation of a procedure prior to anesthesia induction and/or surgical preparation in the operating suite.

Modifier -53 is not valid when a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure.

References

1. American Medical Association. "Appendix A – Modifiers." Current Procedural Terminology (CPT). Chicago: AMA Press.
2. American Medical Association. "Modifiers." CPT Assistant. Chicago: AMA Press, November 1996, p. 19.

Grider, Deborah J. Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage. Chicago: AMA Press, 2004, pp. 109 – 114.

6.3 57; Decision for Surgery

This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc.)

Definitions

This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc.)

CPT modifier - 57 is used when the initial decision to perform a major surgical procedure is made during an E&M service provided the day before or the day of a major surgery.

Major surgery is defined as any code having a 90 day global period.

Policy Statement

KHS will not require a physician to submit clinical information of their patient encounters solely because the physician seeks payment for both surgical procedures and E&M services for the same patient on the same date of service, provided that the correct E&M code, surgical code and modifier (e.g., CPT modifiers 25 or 57) are included on the initial claim submission.

An E&M service provided the day before or the day of a major surgery that resulted in the initial decision to perform surgery is eligible for reimbursement if modifier -57 is appended to the E&M code.

Modifier -57 should not be used when the E&M service is associated with a minor surgical procedure (defined as having a 0 or 10 day global period).

Modifier -57 should not be used when the E&M service was for the preoperative evaluation.

References

1. American Medical Association. “Appendix A – Modifiers”. Current Procedural
   Terminology (CPT), Chicago: AMA Press.

6.4 59; Distinct Procedural Service

This policy does not apply to facilities (hospitals, surgery centers, kidney centers, etc.)

Definitions

CPT modifier -59 represents a procedure or service that is distinct or independent from other services performed on that same day. Modifier -59 identifies procedures or services, other than E&M services, that are not normally reported together but are appropriate under the circumstances.

Policy Statement

CPT codes submitted with modifier 59 attached are considered appropriate coding to the extent they follow the AMA CPT book, and they designate a distinct or independent procedure performed on the same day by the same physician, but only to the extent that:

1) although such procedures or services are not normally reported together, they are appropriately reported together under the particular presenting circumstances; and
2) it would not be more appropriate to append any other CPT recognized modifier to such CPT codes.

KHS does not deny payment for services with a CPT modifier -59 appended based solely on the existence of the modifier -59.

The submission of modifier -59 appended to a procedure code indicates that documentation is available in the patient's records for review upon request that will support the distinct or independent identifiable nature of the service submitted with modifier -59.

CPT codes submitted with modifier 59 attached will be eligible for payment to the extent they not only follow the AMA CPT book, but additionally are not considered a bundled component of a more comprehensive code or two codes that should not be reported together based on NCCI edits or NCCI coding guidelines.

Valid use of modifier -59:

- Differing anatomical site (e.g., skin lesions on separate body sites), different organ system (e.g., laparoscopy on separate organ systems), contralateral structures (e.g., bilateral knees although use of HCPCS modifiers –RT and –LT would be clearer.)
- Separate surgical operative session on the same date of service.

Invalid use of modifier -59:

- Procedures in the same ipsilateral joint (including differing compartments) performed by open, scope, or combined open/scope technique, including added port or incisional sites.
- Procedures in the same anatomical site (e.g., digit, breast, etc.), even with incision lengthening or contiguous incision.
- CPT identified "separate" procedures performed in the same session, same anatomic site, or orifice.
- Scope procedure converted to open procedure.
- Incisional repairs are part of the global surgical package, including deliveries.
- Contiguous structures in the same anatomic site, organ system, or joint.

References

NCCI Policy Manual for Medicare Services, current version Chapter 1.

6.5 Payment of Interest on Late Claims[17]

Interest is automatically paid on late claims in accordance with *KHS Policy and Procedure #60.05-I Payment of Interest on Late Claims*.

7.0 PROVIDER PREVENTABLE CONDITIONS

Provider Preventable Conditions (PPCs) are either Health Care-Acquired Conditions (HCACs) or Other Provider-Preventable Conditions (OPPCs) as defined under 42 CFR 447.26 and must be reported to the Department of Health Care Services (DHCS) and KHS upon discovery in any health care setting. A completed DHCS 7107 form (See Attachment A) must be submitted to the DHCS and to KHS.

7.1 Reimbursement

KHS will not reimburse providers for PPC-related health care services.

7.2 Billing Guidelines

The following guidelines apply to outpatient hospital providers, freestanding ambulatory surgery centers, and acute outpatient hospital provider billing for acute outpatient hospital-based physician services.

Outpatient Hospitals and Freestanding Ambulatory Surgery Centers	
UB-04 or 837I institutional claims	**CMS-1500 or 837P professional claims**
Acute outpatient hospitals and hospitals licensed health centers (HLHCs)	Acute outpatient hospital and HLHC claims for acute outpatient hospital-based physician services
Privately-owned chronic disease and rehabilitation outpatient hospitals	Freestanding ambulatory surgery centers (FASCs
Psychiatric outpatient hospitals	
State-owned non-acute outpatient hospitals operated by the Department of Mental Health (DMH) state-owned non-acute outpatient hospitals operated by the Department of Public Health (DPH)	
Substance abuse treatment outpatient hospitals	

The following guidelines apply to inpatient hospital providers and acute inpatient hospital providers billing for acute inpatient hospital-based physician services.

UB-04 or 837I institutional claims:	**CMS-1500 or 837P professional claims:**
Acute inpatient hospitals	Acute inpatient hospital claims for acute inpatient hospital-based physician services

Privately-owned chronic disease and rehabilitation inpatient hospitals	
Psychiatric inpatient hospitals	
State-owned non-acute inpatient hospitals operated by the Department of Mental Health (DMH)	
State-owned non-acute inpatient hospitals operated by the Department of Public Health (DPH)	
Substance abuse treatment inpatient hospitals	

All inpatient hospital claims related to a PPC must include the appropriate Present on Admission (POA) indicator.

POA Indicator Reporting Description and PPC Payment Criteria for Inpatient Hospitals		
POA Value on UB-04 or 837I	Description	Payment adjustments
Y	Diagnosis was present at time of inpatient admission.	Payment is made for the condition.
N	Diagnosis was not present at time of inpatient admission.	Applicable PPC payment adjustments will be made
U	Documentation is insufficient to determine if the condition was present at the time of inpatient admission.	Applicable PPC payment adjustments will be made.
W	Clinically undetermined. The provider was unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment is made for condition.
Leave field blank	Effective January 1, 2011, the POA field will be left blank for codes exempt from POA reporting. Note: The number "1" is no longer valid on claims submitted under the 5010 format, effective January 1, 2011. Refer to CMS change request 7024 www.cms.gov/transmittals/downloads/R756OTN.pdf	Exempt from POA

8.0 RECOVERY OF OVERPAYMENTS[18]

KHS pursues recovery of overpayments that meet cost-benefit guidelines. When recovery is

pursued, KHS sends a refund request letter to the provider. Within 30 working days of receipt of the letter, the provider must submit to KHS either a complete refund of the overpayment or a provider dispute. Disputes must be submitted and will be processed in accordance with *KHS Policy and Procedure # 6.04 – Practitioner/Provider Disputes Regarding Claims Payment.*[19] As stipulated in the provider contract, if a dispute is not received within 30 working days or the full repayment amount, the overpayment will be offset against additional amounts due to the provider.

Overpayment process will be reviewed by the Claims Director or designee on a quarterly basis for accuracy.

Any recovery of an overpayment to a provider of $25 million or more, KHS and DHCS will share equally. Sixty (60) days after the date that the overpayment was identified, KHS will report the overpayment to the DHCS Contract Manager. KHS will submit the overpayment amount recovered, provider information, and steps taken to prevent future occurrences. This will not include any recoveries retained under the False claims Act or other investigations not covered under APL 17-003.

KHS will report annually to DHCS on all recoveries of overpayments, including network providers excluded from participation in Medicaid program and those made to a network provider due to fraud, waste or abuse. Documentation will include retention policies, processes, timeframes, and documentation required for reporting the recovery of all overpayments, will be provided upon request by DHCS. Report will be submitted through the DHCS Contract Manager.

KHS shall require network providers to report to KHS when it has received an overpayment, to return the overpayment to KHS within sixty (60) calendar days after the date on which the overpayment was identified, and to notify KHS in writing of the reason for the overpayment.

9.0 INQUIRIES REGARDING UNPAID CLAIMS[20]

Providers may confirm the date of receipt of paper claims within 15 working days of receipt by calling 1-800-391-2000. Providers receive an electronic acknowledgement of the receipt of electronic claims within 2 working days of the date of receipt.

10.0 UNFAIR BILLING PATTERNS[21]

Providers who engage in an unfair billing pattern may be reported to the Department of Managed Health Care. Unfair billing patterns include, but are not limited to, demonstrable and unjust patterns of unbundling and up-coding. KHS will make efforts to work with providers to distinguish billing errors from unfair billing patterns and to help providers correct billing errors. Providers will only be reported to DMHC after efforts to resolve such billing issues have failed.

Additionally, Providers need to be aware that Kern Health Systems is contractually obligated to conduct, complete, and report to the Department of Health Care Services the results of a preliminary investigation of suspected fraud and/or abuse within ten (10) working days of the date that KHS first becomes aware of, or is on notice of, such activity.

11.0 MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Pursuant to APL 22-005 and 22-006, KHS will cover all initial mental health assessments by network providers without a referral/authorization. KHS will not deny reimbursement for Non Serious Mental Health Services (NSMHS) provided during the assessment process if the assessment determined that the member does not meet the criteria for NSMHS or meets the criteria to Serious Mental Health Services (SMHS). KHS will not deny reimbursement for NSMHS provided to a member who meets NSMHS criteria on the basis of the member having a co-occurring SUD, when all other Medi-Cal and services requirements are met. KHS will not deny reimbursement for NSMHS provided to a member on the basis of the member also meeting SMHS criteria and/or also received SMHS services provided that the concurrent services are clinically appropriate, coordinated and not duplicative.

ATTACHMENTS:

- Attachment A – DHCS 7107 Form

REFERENCE:

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[1] **Revision 2022-06:** Revised by Claims Director to comply with DHCS APL 22-006 and 22-005, revisions approved by the DHCS on 7/26/2022 and by DMHC on 11/10/2022, Filing No 202223746. **Revision 2021-09:** Added Juneteenth as declared a new federal holiday in 2021. **Revision 2021-08:** Director of Claims added additional required language of 99% of all clean claims are processed in 90 days for ILOS review of P&P. **Revision 2017-05: Added additional required language and processes to comply with APL-17-003 effective 7/1/17. Revision 2016-05:** Revisions to ICD codes. Updated Health Insurance Claim Form provided by Claims Director. **Revision 2016-03:** Policy revised to comply with All Plan letter (APL) 15-006 regarding provider preventable conditions. Additional language added by Director of Claims on reimbursement**.** **Revision 2014-03:** Revised to comply with DHCS Medical Audit review 2013. Section 3.5 new language to include stipulation that misdirected claims are sent to appropriate payer within ten (10) days. References to Healthy Families removed. **Revision 2013-10:** New language added for various modifiers. Contractual requirements for KHS added regarding reporting to the DHCS. **Revision 2011-11:** Revised to comply with new DHCS Contract requirements and made changes to comply with MMCD
Policy Letter 08-002. Added clarifying language that Providers may use the KHS Member Identification Number. **Revision 2010-05:** Policy revised to comply with DHCS Deliverable 7.B. Policy updates provided by Director of Claims. **Revision 2009-01:** Policy revised to comply with MMCD 08-002. **Revision 2008-11:** Revised mailing address for Claims submission, process returned to Bakersfield, CA. Policy Revision date not changed and signatures not required per CCO. **Revision 2008-06:** Routine revision initiated by Claims Manager. Policy reviewed against MMCD All Plan Letter 07-020 Medi-Cal Billing Restriction on the Use of Social Security Numbers 12/26/07 **Revision 2005-08:** Routine review initiated by Director of Claims. Policy reviewed against DHS Contract 03-76165 (Effective 5/1/2004). **Revision 2004-04:** Revised to include 30 business day deadline for claims resubmission. Should have been included in Revision 2003-12. Also updated with new addresses and phone numbers. **Revision 2003-12**: Revised to comply with AB1455 Claims Settlement Regulations; effective 01/01/2004. Revised per request of Claims Manager. Policy #6.03 – Unbundled Claims (2001-03) is deleted and incorporated into this policy. Policy #60.06 – Third Party Liability (2001-08) is deleted and incorporated into this policy and the associated internal policy. **Revision 2002-05:** Revised per DHS request. Clarify that 90 submission deadline applies only to contracted providers. Also added Processing Guidelines section. Revised per Amendment to 2002 Service Agreements (11/8/01). **Revision 2001-03**: Changes made per Provider Relations request. Changed submission deadline from 60 to 90 days to match contract; added HFAM PO Box. Issue date changed to correct previous error.

[1] Health and Safety Code Sections 1371, 1371.35

[2] CCR Title 28 §1300.71(a)(11)

[3] CCR Title 28 §1300.71(a)(10)

[4] CCR Title 28 §1300.71(a)(13)

[5] Title 5 USC 6103 specifies the federal holiday schedule. See www.canb.uscourts.gov/canb/genifo.nsf (click on "general information"; click on "search"; enter "federal holidays" in the search box) for a yearly schedule.

[6] MMCD All Plan Letter 07-020 Medi-Cal Billing Restriction on the Use of Social Security Numbers 12/26/07

[7] CCR Title 28 §1300.71(b)(4)
[8] KHS may not impose a deadline less than 90 days after the date of service (CCR Title 28 §1300.71(b)(1).
[9] KHS may not impose a deadline less than 90 days after the date of payment or date of contest, denial or notice from the primary payer (CCR Title 28 §1300.71(b)(1).
[10] MMCD All Plan Letter 08-002
[11] KHS may not impose a deadline less than 90 days after the date of payment or date of contest, denial or notice from the primary payer (CCR Title 28 §1300.71(b)(1).
[12] MMCD All Plan Letter 07-020
[13] CCR Title 28 §1300.71(o)(1)(B). Also must be electronic.
[14] CCR Title 28 §1300.71(g) and (h); HSC §1371
[15] HFAM Contract 05MHF016 Exhibit B, II B(1). Inclusion requested by B. Davenport.
[16] DHS Contract 03-76165 Exhibit A-08 (6). Non contracting emergency providers are not allowed to balance bill. (DMHC Letters May 12, 2003 and July 2, 2003. See AB1455 information).
[17] HSC §1371
[18] CCR Title 28 §1300.71(d)(3) through (6)
[19] CCR Title 28 §1300.71(d)(4)
[20] CCR Title 28 §1300.71(c)
[21] HSC §1371.39(b)

Medi-Cal Provider-Preventable Conditions (PPC) Reporting Form

By law, providers must identify provider-preventable conditions that are associated with claims for Medi-Cal payment or with courses of treatment furnished to Medi-Cal patients for which Medi-Cal payments would otherwise be available. See instructions for a more detailed description of PPCs.

1. Name of facility where PPC occurred:		
2. National Provider Identifier (NPI):		
3. Billing NPI if different from No. 2:		
4. Facility Address where PPC occurred:		
City:	State:	Zip code:
5. *PPC – Other Provider-Preventable Condition (OPPC) in any health care setting:*		
Date OPPC occurred:	Admission date:	
☐ Wrong surgery/invasive procedure		
☐ Surgery/invasive procedure on the wrong body part		
☐ Surgery/invasive procedure on the wrong patient		
6. PPC – Health Care-Acquired Condition (HCAC) in an acute inpatient setting:		
Date HCAC occurred:	Admission date:	
☐ Air embolism	☐ Blood incompatibility	
☐ Catheter-associated urinary tract infection	☐ Deep vein thrombosis/pulmonary embolism	
☐ Falls/trauma	☐ Foreign object retained after surgery	
☐ Iatrogenic pneumothorax with venous catheterization		
☐ Manifestations of poor glycemic control	☐ Stage III or IV pressure ulcers	
☐ Surgical site infection	☐ Vascular catheter-associated infection	
7. Patient's name:		
8. Client Index Number (CIN):		
9. Patient's birthdate:		
10. Patient's address:		
City:	State:	Zip Code: Apt. No.:
11a. Is the patient enrolled in a Medi-Cal Managed Care Plan? ☐ Yes ☐ No (Fee-for Service)		
11b. If "yes" to question No. 11a, what is the plan's three-digit Health Care Plan Code?		
11c. Name of Health Care Plan:	HCP County:	
12a. Do you intend to submit a claim? ☐ Yes ☐ No ☐ Unknown		
12b. If "yes," what is the claim control number?		
13. Name of person completing report:		
14. Title of person completing report:		
15. Submitted by: ☐ Medi-Cal Managed Care Plan ☐ Provider		
16. Phone (including ext.):	Email:	
17. Signature of person completing form:		

Please note: *When applicable, both Medi-Cal Managed Care Plans (MCP) and Medicare-Medicaid Plans (MMP) are required to report PPCs using this form.*

INSTRUCTIONS

*Providers must complete and send one form (front page only) for each provider-preventable condition (PPC**). Please note that reporting PPCs to the Department of Health Care Services for a Medi-Cal beneficiary does not preclude the reporting of adverse events and healthcare associated infections (HAIs), pursuant to the Health and Safety Code sections 1279.1 and 1288.55, to the California Department of Public Health** for the same beneficiary**. Providers must report any PPC to DHCS that did not exist prior to the provider initiating treatment** for a Medi-Cal beneficiary, even if the provider does not intend to bill Medi-Cal.*

Mark "PROTECTED HEALTH INFORMATION: CONFIDENTIAL" and send completed first page only of the report related to a Medi-Cal beneficiary to:

Via Secure Fax
Department of Health Care Services
Audits and Investigations Division
Occurrence of Provider-Preventable Conditions
(916) 327-2835

Via U.S. Post Office
Department of Health Care Services
Occurrence of Provider-Preventable Condition
Audits and Investigations Division, MS 2100
P.O. Box 997413
Sacramento, CA 95899-7413

Via UPS, FedEx, or Golden State Overnight
Department of Health Care Services
Occurrence of Provider-Preventable Condition
Audits and Investigations Division, MS 2100
1500 Capitol Ave., Suite 72.624
Sacramento, CA 95814-5006

Providers must send this form to the Department of Health Care Services (DHCS), Audits and Investigations Division, via fax, U.S. Post Office, UPS, or FedEx. Providers must submit the form after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary. The preferred methods of sending the reports for confidentiality are No. 1, overnight courier with appropriate marking; No. 2, secure fax machine with appropriate marking; and No. 3, U.S. mail with appropriate marking. Providers must comply with HIPAA and any other relevant privacy laws to ensure the confidentiality of patient information. Providers may email questions about PPCs to PPCHCAC@dhcs.ca.gov.

Facility information (boxes 1-4)

1. Enter name of the facility where the PPC occurred.
2. Enter the National Provider Identifier (NPI) of the facility where the PPC occurred.
3. Enter the billing NPI if it is different from the NPI for the facility where the PPC occurred.
4. Enter the street address, city, state, and zip code of the facility where the beneficiary was being treated when the PPC occurred.

Other Provider-Preventable Condition in any health care setting (box 5)

5. If you are reporting an OPPC, enter the date (mm/dd/yyyy) that the PPC occurred and the admission date if the beneficiary was admitted to an inpatient hospital.

   Select one of the following if:
   - Provider performed the wrong surgical or other invasive procedure on a patient.
   - Provider performed a surgical or other invasive procedure on the wrong body part.
   - Provider performed a surgical or other invasive procedure on the wrong patient.

Health Care-Acquired Condition (HCAC) in an acute inpatient setting (box 6)
(HCACs are the same conditions as hospital-acquired conditions (HACs) that are reportable for Medicare, with the exception of reporting deep vein thrombosis/pulmonary embolism for pregnant women and children under 21 years of age, as noted below.)

6. Enter the date (mm/dd/yyyy) that the HCAC occurred and the admission date the beneficiary was admitted to an inpatient hospital.

Select one of the following if the beneficiary experienced:

- A clinically significant air embolism
- An incidence of blood incompatibility
- A catheter-associated urinary tract infection
- Deep vein thrombosis (DVT)/pulmonary embolism (PE) following total knee replacement or hip replacement in an inpatient setting. Do **not** check the box if the beneficiary was under 21 or pregnant at time of PPC.
- A significant fall or trauma that resulted in fracture, dislocation, intracranial injury, crushing injury, burn, or electric shock
- Any unintended foreign object retained after surgery
- Iatrogenic pneumothorax with venous catheterization
- Any of the following manifestations of poor glycemic control: diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, or secondary diabetes with hyperosmolarity
- A stage III or stage IV pressure ulcer
- One of the following surgical site infections:
  - Mediastinitis following coronary artery bypass graft (CABG)
  - Following bariatric surgery for obesity: laparoscopic gastric bypass, gastroenterostomy, or laparoscopic gastric restrictive surgery
  - Certain orthopedic procedures: Spine, neck, shoulder, and elbow
  - Following cardiac implantable electronic device (CIED) procedures
- A vascular catheter-associated infection

Beneficiary information (boxes 7-11c)

7. Enter beneficiary's name (first, middle, last) as listed on the Beneficiary Identification Card.
8. Enter beneficiary's Client Index Number (CIN) from the Beneficiary Identification Card.
9. Enter the beneficiary's birthdate (mm/dd/yyyy).
10. Enter the beneficiary's home street address, including city, state, zip code, and apartment number, if applicable.

11a. Check "yes" if the beneficiary is enrolled in a Medi-Cal Managed Care Plan or "no" if the beneficiary has Fee-For-Service (FFS) Medi-Cal.

11b. If the beneficiary has Medi-Cal Managed Care, the beneficiary's Managed Care Plan should enter the Health Care Plan's (HCP) three-digit plan code.

11c. If the beneficiary has Medi-Cal Managed Care, enter the name of the Managed Care HCP and the county of the HCP where the PPC occurred.

Claim information (boxes 12a-12b)

12a. Click "yes" if you intend to submit a claim to Medi-Cal for the course of treatment associated with the PPC, "no" if you do not, or "unknown" if you do not know at this time.

12b. Enter the Claim Control Number (CCN) if you have already submitted a claim for the course of treatment.

Provider Contact information (boxes 13-17)

13. Enter the name of the person completing this report.
14. Enter the title of the person completing this report.
15. Check the appropriate box to indicate whether the person completing this report is a representative for a Medi-Cal Managed Care Plan or a provider.
16. Enter a work phone number, including extension if necessary, and email address where DHCS can contact the person who completed this report.
17. Sign and date the form. Adobe “digital signatures” are accepted.

THE INFORMATION CONTAINED IN THE COMPLETED FORMS IS PROTECTED HEALTH INFORMATION AND PERSONALLY IDENTIFIABLE INFORMATION, UNDER FEDERAL (HIPAA) LAWS AND CA STATE PRIVACY LAWS. THE PROVIDER IS RESPONSIBLE FOR ENSURING THE CONFIDENTIALITY OF THIS INFORMATION.